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ACRONYM LIST

BCC	Behavior Change Communication
CADZS	Health Zone Development Support Unit
CBO	Community-Based Organization
CBS	Community-Based Services
CBSA	Community-Based Services Agent
CHD	<i>Centre Hospitalier Départemental</i> (Departmental Hospital Center)
COGEA	<i>Comité de Gestion de l'Arrondissement</i> (Arrondissement Management Committee)
COGEC	<i>Comité de Gestion de la Commune</i> (Commune Management Committee)
CSA	<i>Centre de Santé de l'Arrondissement</i> (Arrondissement Health Center)
CSC	<i>Centre de Santé de Commune</i> (Commune Health Center)
CVS	<i>Comité Villageois de Santé</i> (Village Health Committee)
DDSP	<i>Directeur Départemental de la Santé Publique</i> (Departmental Public Health Director)
DNPS	<i>Direction Nationale de la Protection Sanitaire</i> (National Health Protection Directorate)
DSF	<i>Direction de la Santé Familiale</i> (Family Health Directorate)
ENIAB	<i>Ecole Nationale des Infirmiers et Infirmières du Bénin</i> (Benin National School of Nursing)
EONC	Emergency Obstetrical and Neonatal Care
FHS	Family Health Services
HS	Health Center
HW	Health worker
HZMTS	Equipe d'Encadrement des Zones Sanitaires (Health Zone Management Team)
IEC	Information, Education, Communication
IGA	Income-generating activities
IMCI	Integrated Management of Childhood Illness
MCDI	<i>Medical Care Development International</i>
MCDZS	<i>Médecins Coordonateurs des Zones Sanitaires</i> (Health Zone Coordinating Physicians)
MOH	Ministry of Health
NGO	Non-Governmental Organization
OIS	<i>Offre intégrée des services de santé familiale</i> (Delivery of Integrated Family Health Services)
ORTB	<i>Office de Radiodiffusion et Télécommunications du Bénin</i> (Benin Radio Broadcasting and Telecommunications Bureau)
PMP	<i>Performance Monitoring Plan</i>
PNC	Prenatal Consultation
PROSAF	<i>Programme de Promotion Intégrée de Santé Familiale dans le Borgou et Alibori</i> (Benin Integrated Family Health Program)
PSS	<i>Projet Santé Suisse</i> (Swiss Health Project)
QA	Quality Assurance
SEPD	<i>Service d'Etude, Planification et Documentation</i> (Research, Planning and Documentation Service)
SIGA	<i>Système d'Information pour la Gestion et l'Approvisionnement</i> (Information and Logistics Management System)
SM/BCC	Social Mobilization/Behavior Change Communication

SNIGS	<i>Système National d'Information d Gestion Sanitaire</i> (National System of Health Information and Management)
URC	University Research Co, LLC
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION

The mission of the Benin Integrated Family Health Program in the Borgou/Alibori (PROSAF, *Programme de Promotion Intégrée de Santé Familiale dans le Borgou/Alibori*) *Transition Phase* is to build on PROSAF's accomplishments and ensure the sustainability of results and the continued use of tools. To build on PROSAF's results, actors in the Borgou/Alibori health system, in particular the Departmental Directorate of Public Health (DDSP), must incorporate the interventions and tools introduced by PROSAF. This idea has been incorporated into the design and implementation of the *Transition Phase*.

As part of the groundwork for developing URC's proposal, a meeting was held with each service manager from the Borgou/Alibori DDSP, the Benin National School of Nursing (ENIAB) and the Departmental Hospital Center, to gather each official's impressions of the implementation of PROSAF's first phase. These meetings brought out strengths and weaknesses, as well as the priority areas requiring PROSAF's special attention should the program be extended. The expectations of all those surveyed were taken into account in the proposal drafted by URC and submitted to USAID.

When the *Transition Phase* was launched, the PROSAF technical team proceeded as follows:

1. All program documents were translated into French to facilitate their use by partners.
2. DDSP and health zone counterparts were designated for each of the technical staff members of PROSAF, and each counterpart's responsibilities were outlined.
3. The PROSAF *Transition Phase* technical team was introduced to the DDSP, the Swiss Health Project (PSS), and Medical Care Development International (MCDI).
4. Action plans, indicators and milestones were presented to the DDSP and to the health zone coordinating physicians (MCDZS).
5. A meeting was organized to integrate PROSAF activities into health zone and DDSP strategic and action plans.
6. A consensus meeting was held with DDSP counterparts and technical staff from other partner projects, the PSS and MCDI.
7. PROSAF community mobilization and behavior change communication strategies were presented to health zone counterparts.
8. A methodological framework was developed for institutionalizing PROSAF's intermediate results. This framework was used for planning the counterparts' activities.

This approach created a climate of confidence between the DDSP and the PROSAF *Transition Phase* team, and facilitated DDSP and health zone adoption of PROSAF activities. The DDSP initiated the meeting on the integration of PROSAF *Transition Phase* activities, led the session and actively participated in it. Moreover, sharing the French translations of the basic program documents facilitated communication between the various actors and allowed everyone to be equally well informed from the beginning. All activities supported by PROSAF are now initiated by DDSP and health zone counterparts; the role of PROSAF technical staff is to coach the counterparts and, where needed, provide the financial support required to carry out activities.

Initiating PROSAF *Transition Phase* activities with the full participation of the actors in the Borgou/Alibori health system has been an essential step toward ensuring the lasting impact of PROSAF's achievements.

Main Results by Intermediate Results of SO2 of USAID/Benin			
IR 1 : Improved Policy Environment	IR 2 : Increased Access to Family Health Services and Products	IR 3 : Improved Quality of Services	IR 4 : Increased Demand for Health Services and Prevention Measures
<p>The ability to more effectively manage the human, financial, and material resources as the DDSP and the health zone level has increased.</p> <p>55% of the health workers in the seven health zones were trained in the management of human, financial, and material resources.</p>	<p>The availability of services and products at the community level has increased.</p> <p>57% of villages services by the community-based service agents offer the minimum package of family health services in the zones.</p>	<p>Institutionalization of Quality Assurance at all levels of the health system in Borgou/Alibori.</p> <p>100% of the hospitals in Borgou/Alibori conduct QA activities through their clinical and administrative management improvement networks.</p>	<p>The knowledge and positive attitudes regarding preventive measures and appropriate behaviors improved.*</p> <p>20.000 audience members were exposed to AIDS and family planning in 65 villages through theater plays in the local languages.</p> <p>9 radio spots and three songs on the prevention of diarrhea, and danger signs to watch for in pregnant women, were broadcast by six community radio stations.</p>
<p>The planning and coordination abilities of the activities were reinforced at all levels of the health system in Borgou/Alibori</p> <p>HZMT Performance Index : 86%</p> <p>96% of medical facilities regularly report data to the HZMTs.</p> <p>The participation of the public in the health sector has increased.</p> <p>100 % of the health structure has COGEC.</p> <p>100% of COGEA have work plans.</p> <p>73% of COGEA organize a monthly training session.</p>	<p>The ability to manage family health products has increased on the health zone level.</p> <p>71% of health care providers correctly estimate and submit on time orders for key family health products.</p> <p>The ability of providers from the public and private health centers to offer the minimum package of health services was reinforced.</p> <p>18% of health workers trained in integrated service delivery.</p> <p>82% of public and private health centers of Borgou/Alibori offer the minimum package of integrated family health service.</p>	<p>The ability of health workers to offer quality of care has improved.</p> <p>42% of health care providers trained in IMCI in the four covered health zones.</p> <p>18 % of providers trained in the new integrated family health protocols and in integrated services delivery.</p> <p>60 providers trained in SONU</p> <p>Training supervision has been institutionalized in Borgou/Alibori.</p> <p>Performance Index of the supervision system : 82%.</p>	<p>The ability of HZMTs to train health workers and community-based service agents to communicate the behavior change messages has increased.</p> <p>16 IEC/BCC trainers of the CBSA trained in the BCC curriculum.</p> <p>A curriculum on AIDS prevention was developed and pre-tested by two NGOs.</p> <p>5,000 posters and 2,200 counseling cards on prevention of diarrhea were produced and distributed to health workers and community-based service agents in Borgou/Alibori.</p> <p>13 radio personalities and 9 singers/wisemen were trained in the development of radio spots and songs on family health.</p>

*The KAP survey planned for May/June 2005 will give us a new level of knowledge about the public's family health knowledge, attitudes and practices.

2. PERFORMANCE REVIEW AND ANALYSIS

The PROSAF-*Transition Phase* 2004 Annual Report documents and reviews the progress made by the program as well as its main technical activities for this year, as they relate to the four PROSAF Intermediate Results (IRs) and the related sub-results. The primary accomplishments achieved by each IR are presented in a table in Appendix 1 in order to show their specific contribution to the

Primary Accomplishments

- Plans for institutionalizing ascendant planning and strengthening the operational capacities of adopted and developed health zones.
- Technical support for the MOH in cooperation with PHR*plus* in order to increase decentralization and adoption of integrated program planning.
- Plans developed for institutionalizing community-based services (CBS); restructuring of monitoring tools and supervision in health centers.
- Self-assessment for institutionalizing CBS.
- Finalization of PMP and its data collection tools.
- 35 managers and accountants from health zone offices, zone hospitals, and community health facilities trained in SYSCOHA.
- Development of health zone data quality assessment tools and procedures.
- 23 health workers (MCDZS, Statisticians, and managers for statistics of the health zone of Borgou/Alibori and the CHD) trained in SNIGS data quality assessment.
- 36 action plans budgeted for by the 2005 District Management Committee (COGEA), developed through participatory community-level assessment.
- 91 COGEAs renewed in the seven health zones.
- 212 members of 30 COGEAs trained in their roles and responsibilities, and in management and management assessment.
- Development of a COGEA training module for advocacy
- Tracking of COGEA monthly meetings.

Intermediate Results achieved by USAID/Benin. Quotations from PROSAF partners at all levels were collected and incorporated throughout the report in order to emphasize the impact of certain activities implemented during the year. Given that the *Transition Phase* must ensure the consolidation of PROSAF results and mark the beginning of the sustainability of certain tools and strategies, a table on “The Aspects to be Sustained” was prepared, and appears as Appendix 2. “What remains to be done” addresses the challenges we must face during the 2005 year, which must be devoted to ending these *Transition Phase* activities.

2.1 Intermediate Result 1: Improved Policy Environment

2.1.1 Sub-Intermediate Result 1.1: Improvement of health policies and strategies, and mechanisms for their implementation.

The capacity to more efficiently manage material, financial, and human resources at the DDSP level, as well as in the health zones, was achieved.

Throughout the course of this year, PROSAF concentrated on strengthening the capacities and coaching skills of management supervisors in the health zones.

Strengthening management capacities Twenty-four (24) supervisors and accountants from five (5) zone offices, four (4) zone hospitals, and ten (10) *commune*-level health centers were trained in the SYSCOHA

Accounting System. The topics developed ranged from current operations to provisional and annual financial statements. The CEPAG consultancy firm facilitated the training, which was co-financed by PROSAF and PSS. The goal envisioned with SYSCOHA is to coordinate the practices and behavior of the health zone management teams (HZMT), zone hospitals and *commune*-level health centers by training the participants in uniform accounting and financial management procedures and tools. This training supplements previous training, which allowed all the health zones to computerize their material and financial management through the installation and use of IMO (material management) and PERFECTO (financial management) software. PROSAF and PSS hope this will guarantee transparency in health zone material and financial management, a fundamental aspect in ensuring these facilities' performance.

Coaching Management Supervisors: Completed regularly by PROSAF during monthly HZMT meetings and quarterly sessions devoted to indicators and activities review. Management of delegated funds and financial balance sheets for health training are the main topics at these sessions.

Examples of health zone performance in health activity management:

During the 3rd quarter, an introductory visit by the new director of USAID/Benin gave the DDSP and the health zones the opportunity to demonstrate their ability to manage health activities. The director's visit concerned the activities of the CAME warehouse in Parakou, the Ina shop financed by the income generating activities (IGA), the visit to the *commune* health center in Gamia, and a work session with the HZMT of Bembèrèkè/Sinendé.

In Ina, the USAID Director learned that profits generated by COGEC shop had already served to finance health awareness activities in the villages. An interview with the HZMT of Bembèrèkè/Sinendé enabled him to observe the knowledge acquired by its members and the other health agents through the different activities organized by PROSAF (QA training sessions, planning, management, data monitoring, office and computer supplies, formative supervision, etc.) The HZMT manager expressed all of this: *"When I came here in 1999, I knew nothing about management. Today, I know how to develop a budget action plan and discuss health questions to such an extent that the midwives call me Doyenne, thinking that I am a midwife, even though I am only a manager. I learned all of this thanks to the support of PROSAF."*



In Gamia, the health center repaired by PROSAF, with USAID support, the cleanliness of the premises, the almost quadrupled usage rate, and the enthusiasm of the health workers, meant that COGEC members ultimately convinced the Director of the true positive impact of PROSAF's support on the people. Notably, the COGEC of Gamia, through its renovated center, acquired a generator that assures the center is lit at night. This reality was expressed through the words of this Gamia midwife: *"At night, our center is called Little Paris, that the whole world wants to visit."* This visit was an opportunity to see that the efforts made with respect to health activity management have contributed to improved health benefits.

Strengthening DDSP administrative management: A work session was organized at the initiative of the Secretariat for the Borgou/Alibori DDSP, who expressed a desire that the quality of the benefits in his secretariat be improved in order to set a good example for other health facilities and services under his supervision. During this session, a progress report was prepared concerning activities designed to improve service quality in the secretariats of the DDSP and all health zones. The following emerged from this progress meeting:

- Data collection measuring the extent to which norms were followed by secretariat management was already completed in all offices of the zones of Borgou/Alibori by the head of the DDSP secretariat.

- Data collection on internal client satisfaction in the DDSP secretariat is planned for the first week of October 2004.
- Analysis of collected data will take place in October, and will allow the main problems to be identified. Additionally, once the profile of a model secretariat has been defined, goals can be established for improving services offered by Borgou/Alibori health center secretariats.
- PROSAF will continue to provide technical assistance through close follow-up, and to strengthen the service capabilities of the secretariat so that they may work as a team and to achieve continuous and rapid improvement of provider-quality.

Visit to PROSAF activity sites by USAID/Benin Committee for Project Follow-up: This visit permitted the MOH to better understand PROSAF performance, and make recommendations to better HZMT and DDSP involvement in the planning of partner interventions, so that these interventions can be taken over by the MOH decentralized facilities and become sustainable.

The DDSP and the seven (7) health zones regularly monitor and report more reliable data on family health indicators.

PROSAF continued coaching the HZMT to ensure that the quarterly meetings for review of the performance indicators take place. Apart from Banikoara, which already had its 2nd quarterly meeting, all other health zones incorporated into their respective meetings scheduled for July-August 2004 the monitoring results from the 1st half of 2004. Furthermore, PROSAF provided technical support to the improvement networks (IMCI, EONC, prevention of nosocomial infection, client satisfaction) currently being installed in the health zones and the departmental hospital center. This will allow them to collect the data necessary for calculating family health indicators, which will serve as a starting point for determining the impact of the changes introduced.

The procedures for collecting family health indicator data in private and public health facilities have improved.

Table 1: Health facilities in the public (106) and private (19) sectors who report data to the HZMT

HZMT PERFORMANCE INDEX				
Performance Indicators	1st quarter 2004*	2nd quarter 2004	3rd quarter 2004	Notes
HZMT Performance (criteria fulfilled)	93%	96%	96%	Parakou N'dali recruited its statistician during the 3 rd quarter. The statistician of Kandi left in the 3 rd quarter and a new one was recruited at the end of the quarter. The health zones of Tchaourou and Bembèrèkè Sinendé do not have statisticians.

*In the 1st quarter of 2004, performance was evaluated in 14 private and 105 public health facilities.

The number of private sector health facilities that report data to the HZMT rose from 14 in the 1st quarter to 19 in the 2nd quarter.

However, it must be noted that only 16% of private clinics officially declared and agreed to participate in this process. The difficulty confronted by HZMT and DDSP in mobilizing these facilities is linked to the facilities' lucrative nature, owing to which they see little benefit in participating in data collection (which costs them time and additional resources, and even causes loss of earnings). Much improvement remains to be accomplished in this area and future PROSAF coaching activities will focus on this problem.

Development of norms, procedures, and tools for SNIGS data quality control.

PROSAF has hired a consultant to analyze the quality of the SNIGS data, which is collected by private and public health facilities. The results from this consultation have been reported to PROSAF technical staff and to the DDSP supervisors, among them the manager of SNIGS data, the SEPD. It emerges from this analysis that the reliability of the data collected by the most efficient health zone, with respect to completeness of SNIGS data, N'dali/Parakou, was only 56%. This low quality level led the different DDSP supervisors to better awareness of the necessity of making reliable data available to support the decisions made in health matters. They asked for PROSAF's support in obtaining more reliable data. To this end, norms, procedures, and quality control tools for SNIGS data were developed by the consultant, who formalized them in a training module for data quality control.

Training of CHD and zone MCDZSs, nurses, midwives, and statisticians on quality control of SNIGS data.

The module developed was subsequently used by the SEPD of the DDSP to train 23 health workers, including the MCDZS, statisticians from the zone offices and zone hospitals of the health zone of Borgou, including the CHD, concerning SNIGS data quality control. This training took place under the effective supervision of the DDSP himself. Those of Alibori must still be trained in the 4th quarter of 2004. We hope that the knowledge acquired will be used to permit the health system of Borgou/Alibori to make use of quality data from now on, thereby serving as an example on the national level.

Furthermore, this training will strengthen the capabilities of the principle participants in the improvement networks, particularly in the zone hospitals, for whom reliable data collection in measuring and tracking improvements is crucial.

The data quality control process, through use of procedures, norms, and tools to evaluate the quality of SNIGS data, taught to MCDZs and the statisticians consists of verifying that there are no obvious errors in the sample, that the local registries have been properly completed for the sample, and by verifying consistency in subsequent compilations linked to this sampling. The most widely adopted method taught was **LQAS (Lot Quality Assurance Sampling)**. This method has the advantage of being based on a small random sample. In the particular case of SNIGS data, in order to obtain a degree of accuracy of 95%, the maximum group size is 19 tools. The study of these 19 tools will determine, with an error risk of 7%, if the target quality level of 95% is attained or not. Therefore, for the goal of 95%, the minimum number of error-free tools is 16, out of the 19 selected tools. The suggested strategy for periodic quality assessment is as follows:

- Prepare an exhaustive list of the available tools.
- Make a random sample of 19 tools.
- Conduct an exhaustive verification of the content of these data cells and make a determination as to accuracy.

ERPA3 data collection and analysis

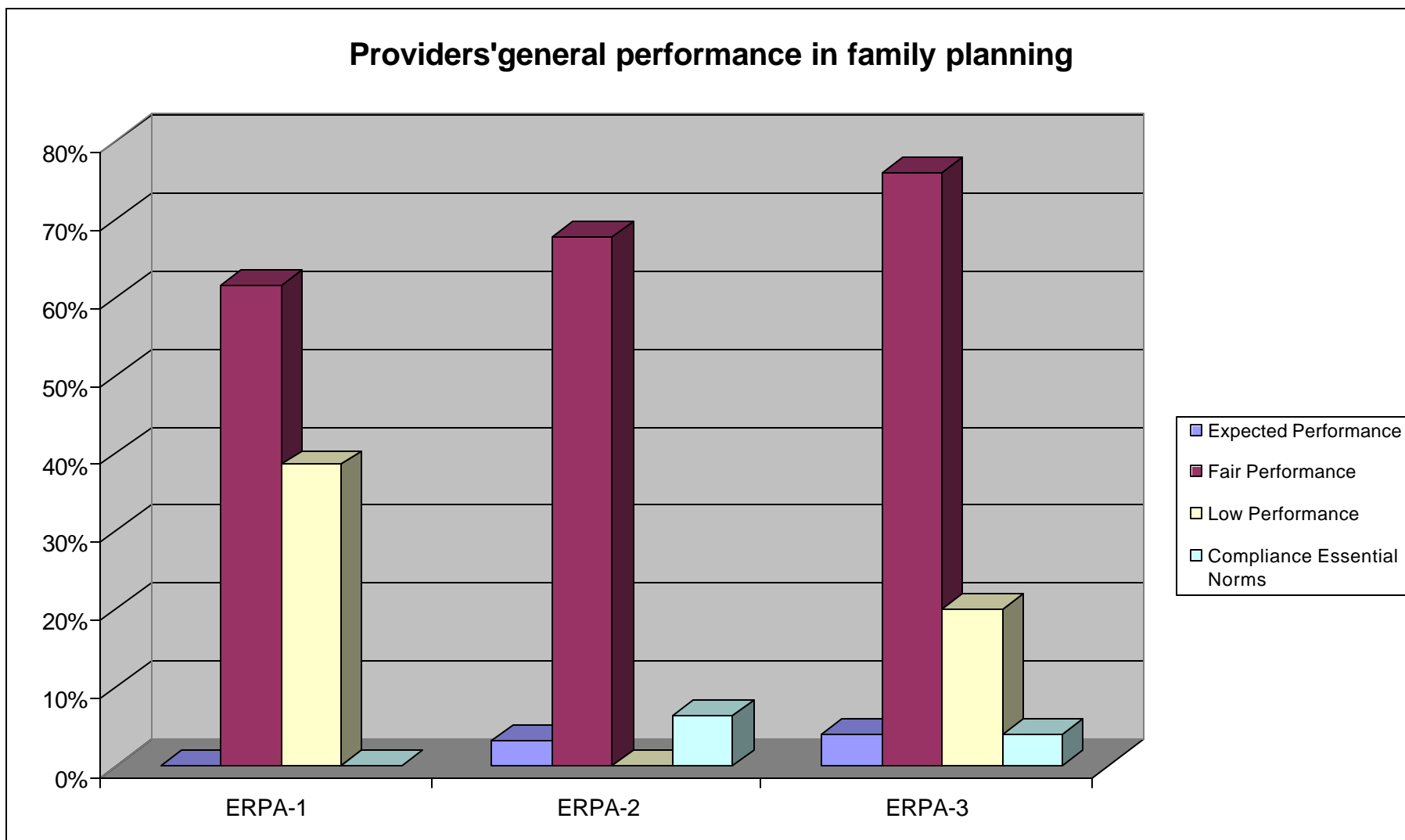
PROSAF and the seven health zones jointly organized and financed the 3rd edition of ERPA this year. To this end, PROSAF recruited a consultant who, before data collection began, trained the health zone data collection teams on data entry using the revised data collection tools, and on the use of a synchronized data entry form installed in each health zone office. Data were collected in each health zone by a team of four (4) people, among them the MCDZS (the team director), the nurse, the zone midwife (experienced in ERPA or EQGSS), as well as a driver. The evaluation concentrated on the same health centers as the 2 previous editions, however this time, the seven health zones evaluated the following four (4) sectors: IMCI, PNC, PoNC, and childbirth. The completed questionnaires were brought directly to PROSAF, where a team of three data-entry clerks compiled them, after verifying their completeness under the consultant's supervision. A duplicate data entry was completed in order to minimize all entry errors and assure the quality of the data. The consultant analyzed the data in accordance with the analysis plan used for the two previous editions. The completed questionnaires are scheduled to be returned to each health zone after processing, so that each health zone can enter and analyze its own data. The preliminary results are presented in the summary tables on the following pages.

Providers' general performance in family planning

Indicators		Banikoara	Bembèrèkè Sinende	Kandi Gogonou Segbana	Malanville Karimame	Nikki Kalalé Pèrèrè	Parakou N'dali	Tchaourou	Total
Expected Performance	ERPA1 Mar03	0/5=0%	0/3=0%	0/12=0%	0/5=0%	0/3=0%	0/5=0%	0/6=0%	0/39=0%
	ERPA2 Dec03	1/1=100%	0/2=0%	0/2=0%	0/15=0%	0/2=0%	0/9=0%		1/31=3.2%
	ERPA3 Nov04	0/1=0%	1/7=14.3%	0/6=0%	0/8=0%	0/3=0%			1/25=4%
Low Performance	ERPA1 Mar03	1/5=20%	3/3=100%	1/12=8%	2/5=40%	1/3=33%	3/5=60%	4/6=66.7%	15/39=38.5%
	ERPA2 Dec03	0/1=0%	1/2=50%	0/2=0%	0/15=0%	1/2=50%	7/9=77.8%		9/31=29.0%
	ERPA3 Nov04	0/1=0%	2/7=28.6%	1/6=16.7%	1/8=12.5%	1/3=33.3%			5/25=20%
Fair Performance	ERPA1 Mar03	4/5=80%	0/3=0%	11/12=91.7%	3/5=60%	2/3=66.7%	2/5=40%	2/6=33%	24/39=61.5%
	ERPA2 Dec03	0/1=0%	1/2=50%	2/2=100%	15/15=100%	1/2=50%	2/9=22.2%		21/31=67.7%
	ERPA3 Nov04	1/1=100%	4/7=57.1%	5/6=83.3%	7/8=87.5%	2/3=66.7%			19/25=76%
Compliance with essential norms for family planning	ERPA1 Mar03	0%	0%	0%	0%	0%	0%	0%	0%
	ERPA2 Dec03	1/1=100%	0/2=0%	0/2=0%	1/15=6.7%	0/2=0%	0/9=0%		2/31=6.5%
	ERPA3 Nov04	0/1=0%	1/7=14.3%	0/6=0%	0/8=0%	0/3=0%			1/25=4%

Expected = Providers comply with all the norms; **Low**= Provider comply with less than 50% of the norms ; **Fair** = Providersr comply with more than 50% but less than 100% of the norms;
Essential = Provider comply with all the norms selected as essential

In regards to family planning, there has been a steady improvement of provider performance in the Expected Performance and Faire Performance categories while a segment of the providers exhibited a weak performance that progressively decreased. ERPA-3 reveals that 76% of the providers now apply at least 50% of the family planning standards. However, the segment of those that apply the critical standards of family planning remains weak.

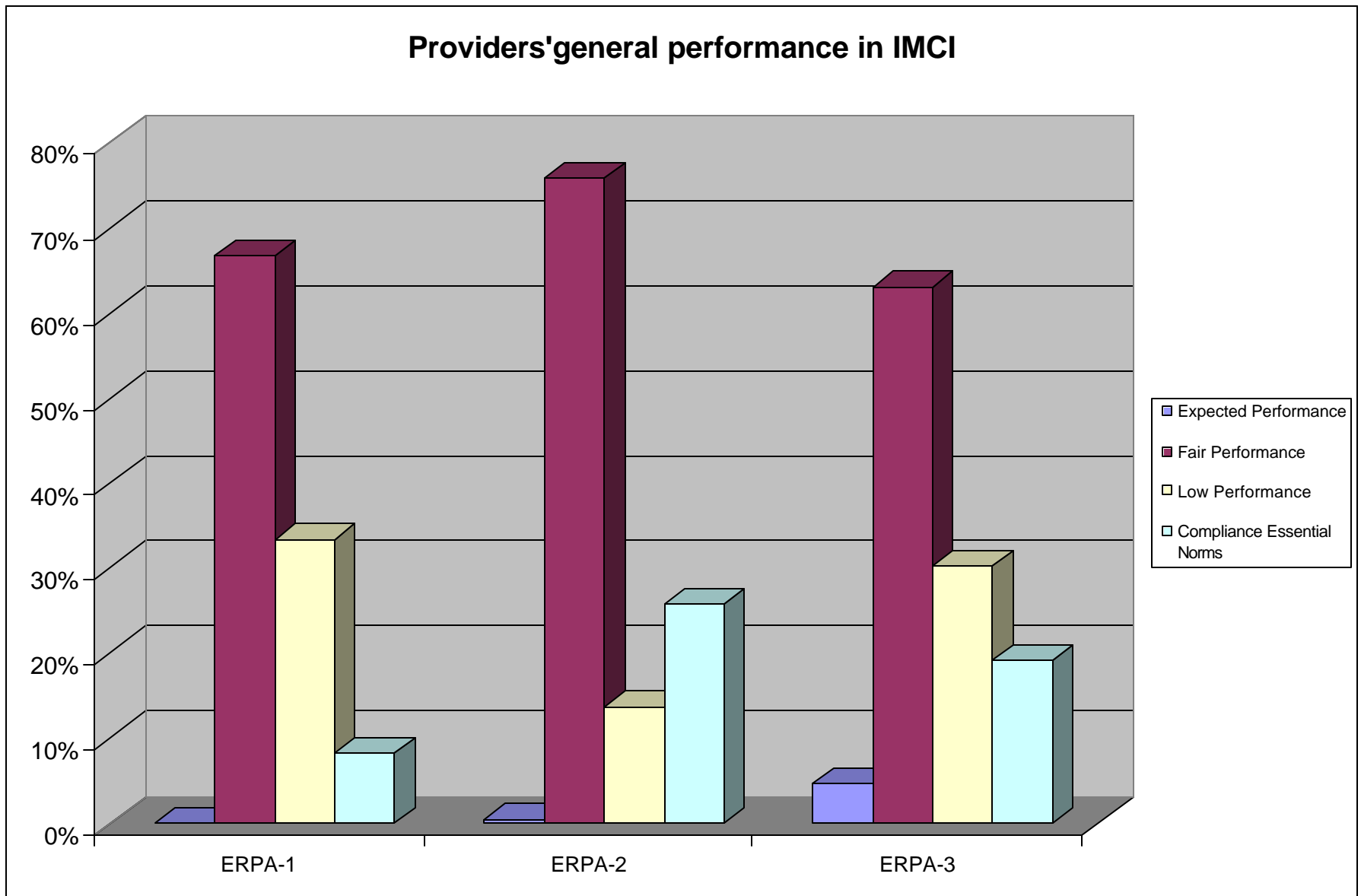


Provider general performance in IMCI

Indicators		Banikoara	Bembèrèkè Sinende	Kandi Gogonou Segbana	Malanville Karimame	Nikki Kalalé Pèrèrè	Parakou N'dali	Tchaourou	Total
Expected performance	ERPA1 Mar03	0/42=0%	0/14=0%	0/15=0%			0/11=0%	0/14=0%	0/96=0%
	ERPA2 Dec03	8/22=36.4%	0/9=0%	0/18=0%		1/22=4.5%	4/41=9.8%	0/12=0%	13/124=10.5%
	ERPA3 Nov04	6/19=31.6%	0/17=0%	0/32=0%	0/19=0%	0/28=0%	0/13=0%	1/21=4.8%	7/149=4.7%
Low performance	ERPA1 Mar03	15/42=35.7%	13/14=92.9%	2/15=13.3%			2/11=18%	0/14=0%	32/96=33.3%
	ERPA2 Dec03	0/22=0%	0/9=0%	0/18=0%		7/22=31.8%	8/41=19.5%	2/12=16.7%	17/124=13.70%
	ERPA3 Nov04	0/19=0%	0/17=0%	6/32=18.8%	18/19=94.7%	16/28=57.1%	5/13=38.5%	0/21=0%	45/149=30.2%
Fair performance	ERPA1 Mar03	27/42=64.3%	1/14=7%	13/15=86.7%			9/11=81.8%	14/14=100%	64/96=66.7%
	ERPA2 Dec03	14/22=63.6%	9/9=100%	18/18=100%		14/22=63.6%	29/41=70.7%	10/12=83.3%	94/124=75.8%
	ERPA3 Nov04	12/19=63.2%	17/17=100%	26/32=81.3%	1/19=5.3%	12/28=42.9%	6/13=46.2%	20/21=95.2%	94/149=63.1%
Compliance with essential norms for IMCI	ERPA1 Mar03	0/42=0%	0/14=0%	4/15=26.7%			4/11=36.4%	0/14=0%	8/96=8.3%
	ERPA2 Dec03	9/22=40.9%	0/9=0%	0/18=0%		1/22=4.5%	12/41=29.3%	10/12=83.3%	32/124=25.8%
	ERPA3 Nov04	14/19=73.7%	2/17=11.8%	0/32=0%	0/19=0%	7/28=25%	4/12=33.3%	1/19=5.3%	28/146=19.2%

Expected = Providers comply with all the norms; Low= Providers comply with less than 50% of the norms; Fair = Providers comply with more than 50% but less than 100% of the norms; Essential= Providers comply with all the norms selected as essential

In all of Borgou/Alibori, more than 60% of the providers apply at least 50% of the IMCI norms. Approximately 20% apply all of the essential IMCI norms (more than 40 norms). This performance is weak in the IMCI zones such as Kandi/Gogounou/Segbana and Nikki/Kalalé/Pèrèrè where all the providers are trained at the IMCI clinic and benefit from follow-up training. By contrast, in the PROSAF concentration zones, Banikoara and Bembèrèkè-Sinende, the performance is better largely due to the fact that on one hand, the providers in these two zones benefited from more training in interpersonal communication skills, and on the other hand, the coordinating doctors have proven strong leadership skills in the follow-up and supervision of health workers



Providers' general performance in prenatal care (PNC)

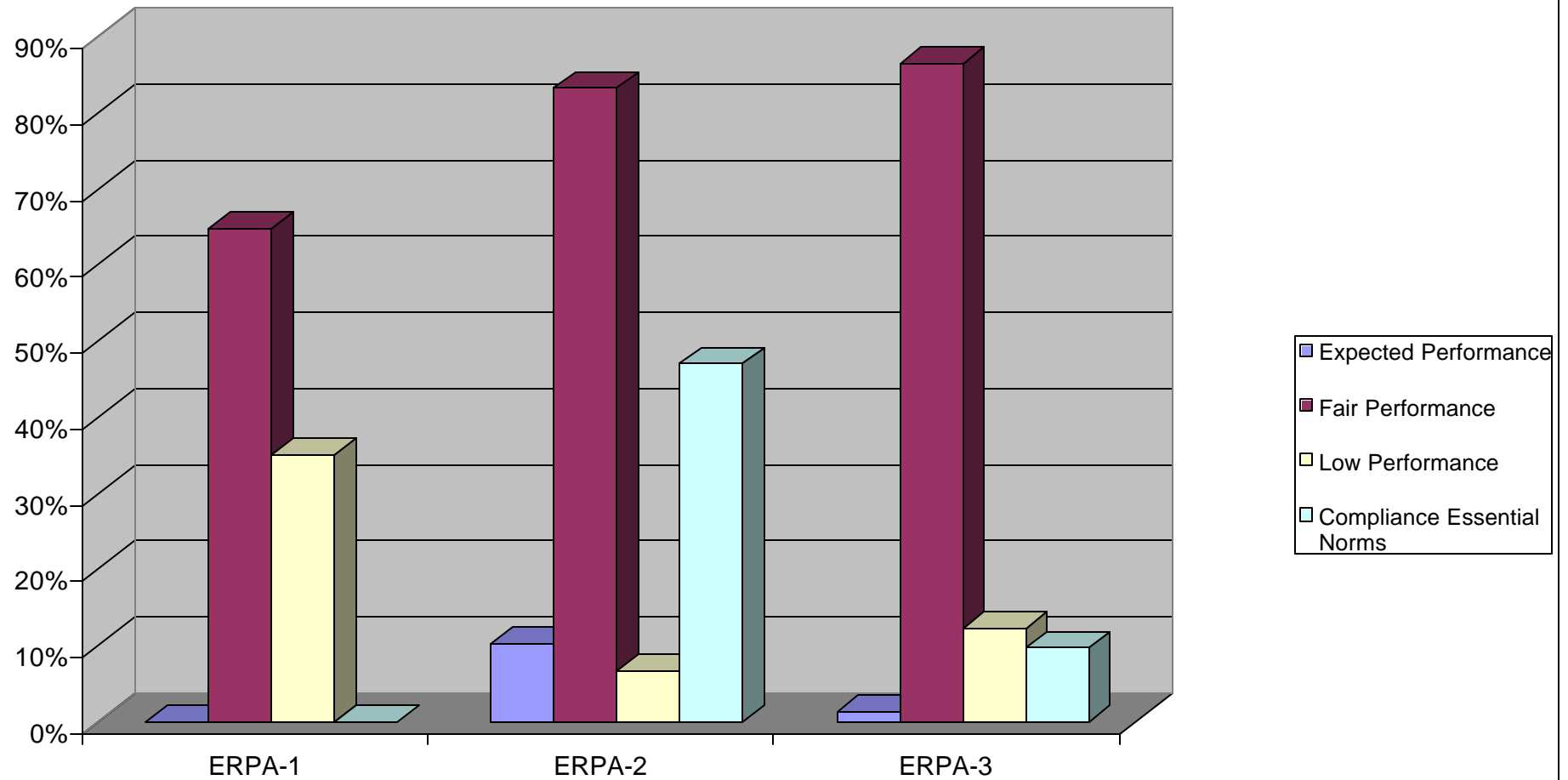
Indicators		Banikoara	Bembèrèkè Sinende	Kandi Gogonou Segbana	Malanville Karimame	Nikki Kalalé Pèrèrè	Parakou N'dali	Tchaourou	Total
Expected Performance	ERPA1 Mar03	0/20=0%	0/30=0%		0/18=0%	0/40=0%	0/23=0%	0/11=0%	0/142=0%
	ERPA2 Dec03	8/19=42.1%	31/2=6.5%		2/21=9.5%	0/21=0%	2/35=5.7%	0/10=0%	14/137= 10.2%
	ERPA3 Nov04	0/17=0%	0/21=0%	0/32=0%	1/23=4.3%	1/303.3%	0/18=0%	0/14=0%	2/155=1.3%
Low Performance	ERPA1 Mar03	1/20=5%	24/30=80%		4/18=22%	14/40=35%	1/23=4%	6/11=54.5%	50/142= 35%
	ERPA2 Dec03	1/19=5.3%	1/31=3.2%		0/21=0%	3/21=14.3%	4/35=11.4%	0/10=0%	9/137= 6.6%
	ERPA3 Nov04	2/17=11.8%	1/21=4.8%	6/32=18.8%	0/23=0%	5/30=16.7%	5/18=27.8%	0/14=0%	19/155=12.3%
Fair Performance	ERPA1 Mar03	19/20=95%	6/30=20%		14/18=77.8%	26/40=65%	22/23=95.7%	5/11=45.5%	92/142= 64.8%
	ERPA2 Dec03	10/19=52.6%	28/31=90.3%		19/21=90.5%	18/21=85.7%	29/35=82.9%	10/10=100%	114/137= 83.2%
	ERPA3 Nov04	15/17=88.2%	20/21=95.2%	26/32=81.3%	22/23=95.7%	24/30=80%	13/18=72.2%	14/14=100%	134/155=86.5%
Compliance with essential norms for PNC (CEN)	ERPA1 Mar03	0/20=0%	0/30=0%		0/18=0%	0/40=0%	0/23=0%	0/11=0%	0/142= 0%
	ERPA2 Dec03	10/19=53%	15/31= 49%		12/21=57.1%	10/21= 48%	16/35= 46%	4/10=40%	65/137= 47%
	ERPA3 Nov04	4/17=23.5%	0/21=0%	1/32=3.1%	8/23=34.8%	0/29=0%	0/18=0%	2/14=14.3%	15/154=9.7%

Expected = Providers comply with all the norms; Low= Providers comply with less than 50% of the norms; Fair = Providers comply with more than 50% but less than 100% of the norms;

Essential = Providers comply with all the norms selected as essential

With regards to pre-natal care, the proportion of providers that apply more than half of the standards has significantly improved. The number climbed from 64.8% in March 2003 to 86.5% in November 2003. However, the providers do not always respect all of the essential norms even though the supervision training has not lowered in intensity (except in Nikki/Kalalé/Pèrèrè). This is perhaps due to the number of essential norms (more than 40) that the providers need to apply in the course of a single interaction with a client.

Providers' general performance in Prenatal Care



Providers' general performance in post natal care (PoNC)

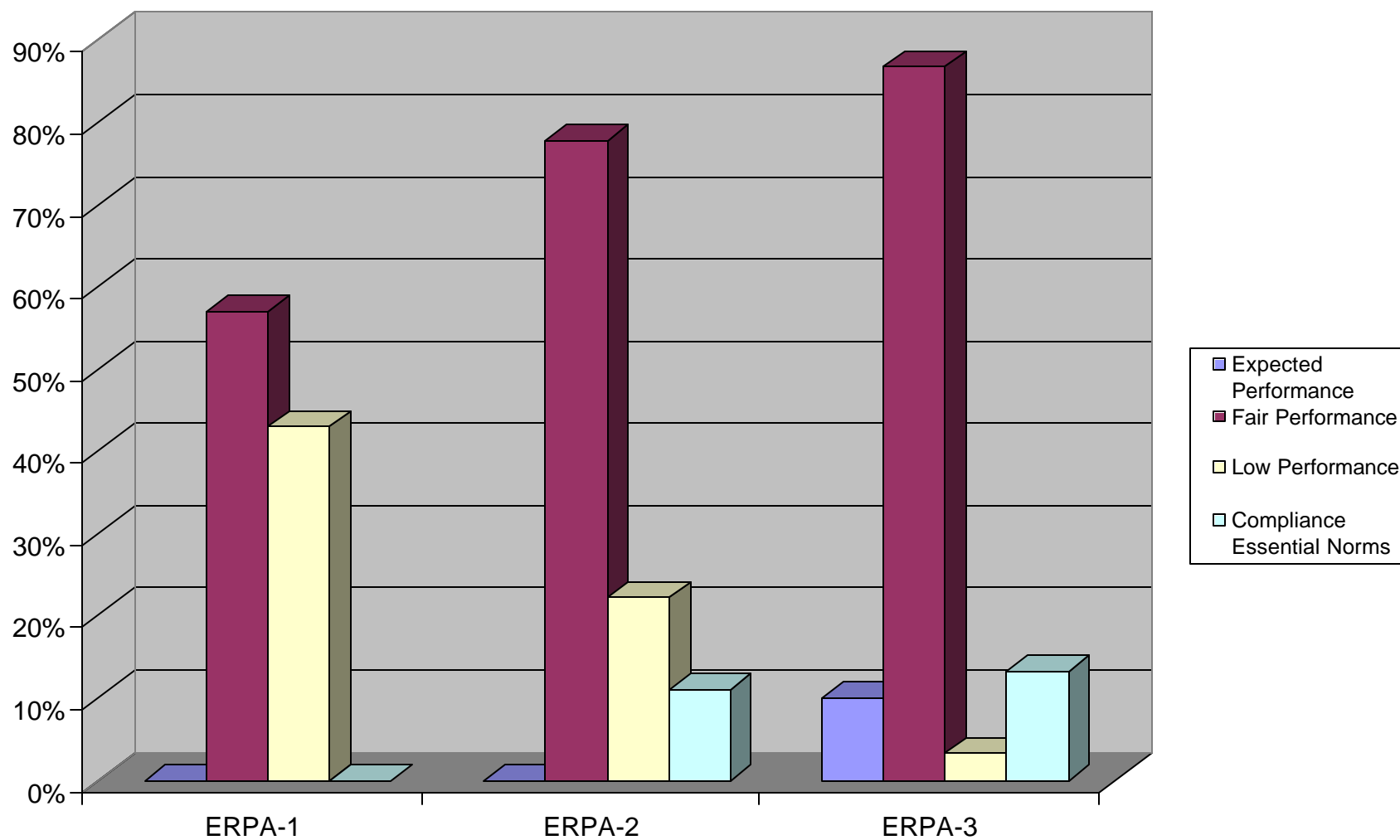
Indicators		Banikoara	Bembèrèkè Sinende	Kandi Gogonou Segbana	Malanville Karimame	Nikki Kalalé Pèrèrè	Parakou N'dali	Tchaourou	Total
Expected Performance	ERPA1 Mar03			0/16=0%		0/5=0%			0/21=0%
	ERPA2 Dec03	0/2=0%	0/4=0%	0/16=0%		0/5=0%	0/4=0%	0/5=0%	0/36=0%
	ERPA3 Nov04	1/2=50%	0/5=0%	0/8=0%	0/2=0%	2/11=18.2%	0/2=0%		3/30=10%
Low Performance	ERPA1 Mar03			6/16=37.5%		3/5=60%			9/21=42.9%
	ERPA2 Dec03	0/2=0%	0/4=0%	0/16=0%		1/5=0%	1/4=25.0%	0/5=0%	8/36=22.2%
	ERPA3 Nov04	0/2=0%	0/5=0%	0/8=0%	0/2=0%	0/11=0%	1/2=50%		1/30=3.3%
Fair Performance	ERPA1 Mar03			10/16=62.5%		2/5=40%			12/21=57%
	ERPA2 Dec03	2/2=100%	4/4=100%	10/16=62.5%		4/5=80.0%	3/4=75.0%	5/5=100%	28/36=77.8%
	ERPA3 Nov04	1/2=50%	5/5=100%	8/8=100%	2/2=100%	9/11=81.8%	1/2=50%		26/30=86.7%
Compliance with essential norms for PoNC	ERPA1 Mar03			0/16=0%		0/5=0%			0/21=0%
	ERPA2 Dec03	1/2=50%	0/4=0%	0/16=0%		0/5=0%	0/4=0%	4/5=80%	4/36=11.1%
	ERPA3 Nov04	1/2=50%	0/5=0%	1/8=12.5%	0/2=0%	2/11=18.2%	0/2=0%		4/30=13.3%

Expected = Providers comply with all the norms; **Low** = Providers comply with less than 50% of the norms; **Fair** = Providers comply with more than 50% but less than 100% of the norms;

Essential = Providers comply with all the norms selected as essential

Post-natal care is an area in which the performance of the providers has improved across the board. The proportion of providers that apply all the critical standards increased from 0% in March 2003 to 13.3% in November 2004. 86.7% of providers now apply at least half of the standards; only 57% maintained the same level of performance as in March 2003.

Providers' general performance in Post Natal Care



Providers' general performance in childbirth care

Indicators		Banikoara	Bembèrèkè Sinende	Kandi Gogonou Segbana	Malanville Karimame	Nikki Kalalé Pèrèrè	Parakou N'dali	Tchaourou	Total
Expected Performance	ERPA1 Mar03								
	ERPA2 Dec03		0/2=0%		0/6=0%	0/1=0%	0/3=0%		0/12=0%
	ERPA3 Nov04	0/2=0%	0/1=0%	0/1=0%		1/3=33.3%	0/3=0%		1/10=10%
Low Performance	ERPA1 Mar03								
	ERPA2 Dec03		0/2=0%		0/6=0%	0/1=0%	0/3=0%		0/12=0%
	ERPA3 Nov04	0/2=0%	0/1=0%	1/1=100%		0/3=0%	1/333.3%		2/10=20%
Fair Performance	ERPA1 Mar03								
	ERPA2 Dec03		2/2=100%		6/6=100%	1/1=100%	3/3=100%		12/12=100%
	ERPA3 Nov04	2/2=100%	1/1=100%	0/1=0%		2/3=66.7%	2/3=66.7%		7/10=70%
Compliance with essential norms for childbirth	ERPA1 Mar03								
	ERPA2 Dec03		0/2 = 0%		1/6=16.7%	0/1=0%	0/3=0%		1/12=8.3%
	ERPA3 Nov04	½=50%	0/1=0%	0/1=0%	0/1=0%	1/3=33.3%	0/3=0%		2/10=20%

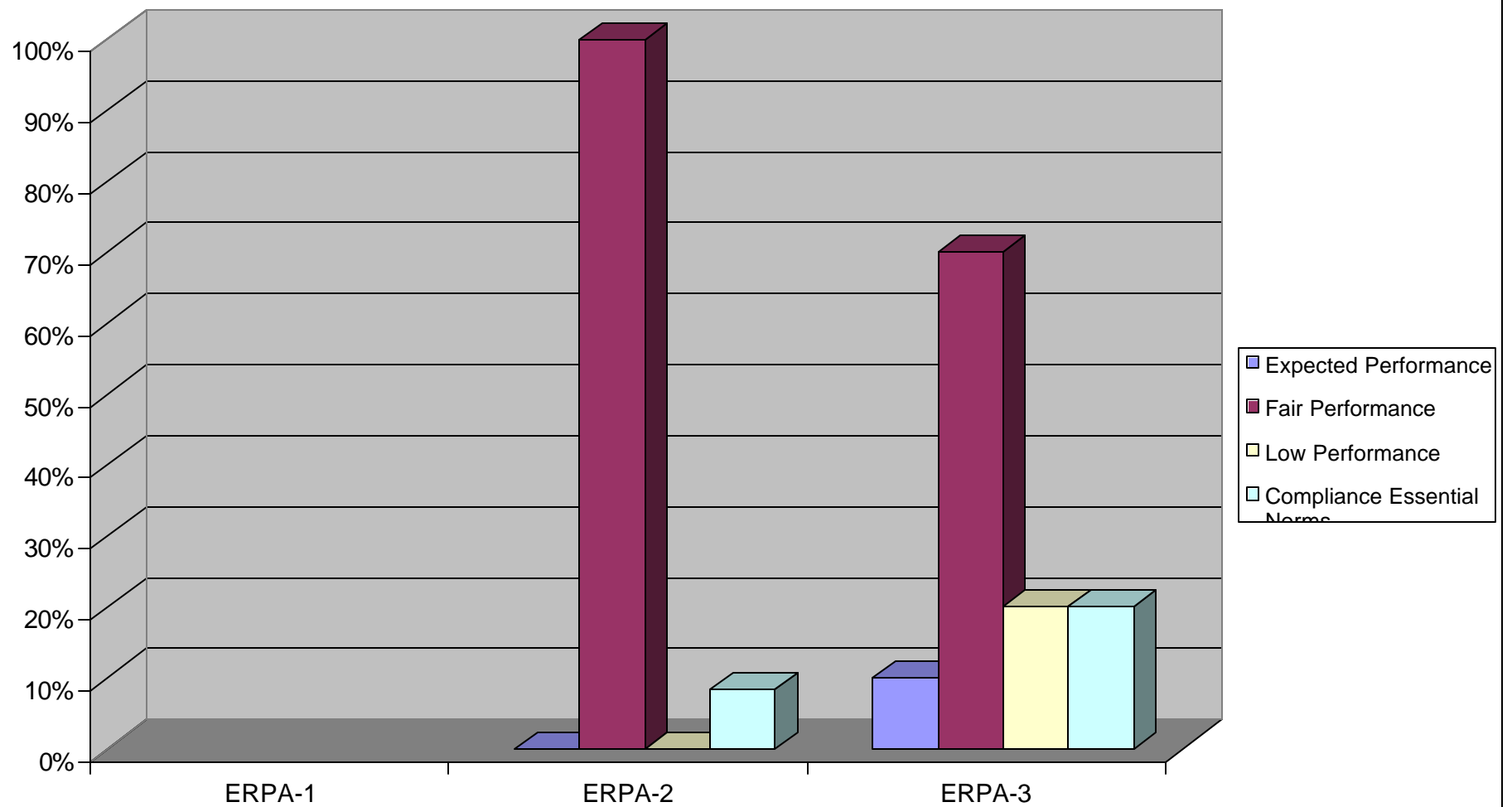
Expected = Providers comply with all the norms; **Low**= Providers comply with less than 50% of the norms; **Fair** = Providers comply with more than 50% but less than 100% of the norms;
Essential= Providers comply with all the norms selected as essential

In regards to assisted childbirth, it is difficult to have a precise idea given the low number of childbirths (10) recorded during the eight (8) day period that ERPA usually covers. However the ERPA-3 figures show that in 70% of the cases, more than half of the standards are applied by providers. 20% apply all the critical standards.

In conclusion, the comparison between ERPA1, ERPA2, and ERPPA3 results shows that the proportion of health workers that apply more than half of the standards (Fair Performance) has significantly increased between March 2003 and November 2004 and is about 60% in all the categories as shown in the graphs below.

In addition, the respect by the evaluated health care providers of all the essential norms in all of the various services (approximately 40 critical standards per service) remains a challenge. However, the performance in the application of the standards is more important in the health zones where the providers, trained in clinical IMCI, benefited from good interpersonal communication skills, and where the coordinating doctor showed strong leadership skills.

Providers' general performance in Childbirth Care



The logistics of tracking data

PROSAF continued throughout 2004 to strengthen the data-tracking system it had begun establishing in the previous years. This system includes 1) a PROSAF *Transition Phase* Performance Monitoring Plan (PMP) consisting of 39 indicators with the appropriate tools for collection and summary of data, 2) mechanisms for strengthening health worker capacity, such as training and coaching of HZMTs in the use of data for decision-making, and providing support to all health zones for the quarterly indicator review, 3) the creation of new databases such as performance indicators, ERPA, formative supervision, and improvement networks.

The data collected is used for decision-making at all levels of the private and public health system of Borgou/Alibori.

Coaching the HZMTs in the use of data

PROSAF continued to coach the HZMTs in conducting quarterly indicator and activity review meetings, so that they may make relevant decisions for improving the quality of healthcare benefits and management services. PROSAF often took advantage of its participation in HZMT monthly evaluation and micro-planning meetings, and in the quarterly indicator and activities review meetings, to motivate and provide the HZMTs with the needed technical support. Data collected by the HZMTs for documenting the effects of the changes introduced by the collaborative model implemented in 2003 was processed during the two main workshops organized this year. The first workshop validated the plans for institutionalizing PROSAF results and the QA achievements in the health centers and in some zone-level hospitals were presented using data. The second was a workshop for planning the implementation of improvement networks.

The DDSP and PROSAF made two joint visits to ensure that implementation of the improved networks in the zone hospitals were being tracked. These trips also allowed them to make health workers aware of the importance of data-based decision-making, and to show them how to use this method.

Finalization, installation, and testing of performance indicators.

During the course of this year, PROSAF also finalized the family health performance indicators chart. This application was then installed in the health zone offices. PROSAF had a work session in each health zone office with the health zone statistician in order to test the software for the performance indicators. These sessions allowed the statistician and PROSAF to:

- Conduct inventory and inspection of the existing database for monitoring indicators, which was installed by PSS.
- Compare the structures of existing indicators, calculation methods, and data collection tools, with the indicator descriptions.
- Identify indicators from the descriptions that do not exist in the software.
- Explore the data entry form and then proceed to input data.

Only health zone statisticians will continue inputting entries, in order to familiarize themselves with this tool.

Workshop on distributing the results of the study on the sustainability of PROSAF results.

USAID organized a dissemination workshop to share results from an evaluation of the process used by process to make its results sustainable. Participating in this workshop were: MOH representatives (General Secretary, DFH, DPP, CADHZ), the DDSP and supervisors, the MCDZS representatives, PSS and MCDI representatives, and the USAID Family Health Team. Following the presentation of the results, four groups worked on a topic related to implementing PROSAF sustainability at the national level: 1) the best PROSAF practices and results targeted for sustainability, 2) financing this sustainability, 3) authorization of the action plan for sustainability proposed by the evaluators, and 4) the responsibility of the main participants in this sustainability. Each group's results were presented and reviewed in their entirety. These results were the main outcomes of this important workshop and they will be integrated into the USAID "Country Strategic Plan" currently being developed and used to lobby and open a political dialogue with the MOH and other backers of the Beninese health sector. It is important to note that the MOH has since perceived PROSAF as a concept that the MOH would like to adopt and implement in all other health zones of Benin.

2.1.2 Sub-Intermediate Result 1.2: Management, planning, and coordination capacities strengthened at all levels of the health system.

The DDSP and the seven (7) health zones improve the implementation of their strategic and yearly (operational) action plans.

PROSAF, after putting into place the plan institutionalizing the ascendant planning process, emphasized coaching the HZMTs and the DDSP in the implementation of their own annual and strategic plans. Therefore, each HZMT was able to accomplish a quarterly review of its 2004 action plan. This review consists of reporting the progress of activities planned and executed during the quarter in question, identifying the obstacles and opportunities, and planning program activities achievable in the next quarter. The DDSP assumed leadership over this process by demanding that each health zone submit a quarterly review of its annual action plan accompanied by a report addressed to the DDSP. Consequently, the first CODIR meeting of 2004 was organized (the meetings of the first and second quarters having been postponed due to the cholera and meningitis epidemics). Personally presided over by members of the DDSP, this CODIR meeting had in attendance all of the MCDZS, the DDSP supervisors and its partners, PSS and PROSAF. Each MCDZS reported the progress of activities executed during the first semester of 2004, as well as the extent to which designated funds had been consumed. These MCDZS have since been responsible for managing designated funds, managing the difficulties encountered during implementation of activities, and suggesting solutions to these problems. The DDSP gave a progress report concerning the performance level of its action plan by way of an SPPS presentation showing the performance of Borgou/Alibori with respect to vaccination coverage. The presentation discussed the strategies implemented to manage epidemics, as well as the difficulties encountered. Of note was that Sinendé is the municipal district recording the highest rate of vaccination coverage and SNIGS data completeness. It was therefore suggested that this health team be congratulated for its performance, in the form of a performance incentive, a key element in the institutionalization plans.

PROSAF took advantage of this CODIR meeting to report the results of the first follow-up visits tracking the implementation of IMCI and EONC networks, and noted the high level of commitment of participants in the field. The praiseworthy initiative of participants was noted particularly at the Papané hospital in the health zone of Tchaourou, where hospital workers were trained as instructors in the revised family health protocols, and organized data reporting sessions with their coworkers. This allowed them to begin applying these protocols to EONC, without having to wait for the formal training of all hospital providers in EONC.

DDSP partners advised that CODIR meetings be organized regularly. This should allow time for brainstorming about how to manage an unexpected epidemic (instead of just reporting the epidemic to the CODIR when it suddenly arrives.) Furthermore, the DDSP identified four major challenges it would like, with the aid of its colleagues, to bolster: 1) the appropriation of PROSAF results; 2) competent management of funds designated for the health zone; 3) improve epidemiological surveillance, in order to control the cholera and polio field virus; and 4) implementation and regular tracking of IMCI and EONC collaborative networks.

Finally, PROSAF continued to monitor the performance of the HZMTs and the trends for this year are as follows:

Table 2: Performance Index for Health Zone Management Teams

TABLE 2: PERFORMANCE INDEX FOR HZMTs				
Performance Indicators	1st Quarter 2004	2nd Quarter 2004	3rd Quarter 2004	Notes
HZMT Performance (All criteria fulfilled)	71 %	71%	86%	Calculated from the 3-criterion* score and compared to the total score predicted

*(1) At least one HZMT meeting was held during the previous quarter, (2) At least 75% of the activities planned for the quarter were executed, (3) Routine data regarding health information for the previous quarter has been compiled by each zone.

The above results indicate that health zone performance improved throughout 2004. Performance went from 71% in the 1st quarter to 86% in the 3^d quarter. With the exception of Tchaourou, which has not been able to execute at least 75% of its planned activities due to numerous obstacles at the central level linked to its strategic position in the struggle against Polio in Benin, all other health zones achieved a performance of 100%. Previous concerns over executing all of the planned activities, holding coordination meetings, and better managing routine health data are no longer an issue, as the HZMTs have resumed these practices. With the effective implementation of designated funds, the health zones have achieved a certain financial autonomy, and consequently greater freedom in executing their action plans. They take increased initiative, and better manage obstacles.

The ascendant process for the design and implementation of operational and strategic plans is institutionalized.

The strengthened planning capabilities of the DDSP and the health zones was marked this year by PROSAF support in developing, validating, and distributing a plan for institutionalizing the ascendant planning process for the design and implementation of operational and strategic plans. Several activities led to this important milestone:

1. Self-assessment of the ascendant planning process at the level of the seven health zones and the DDSP was completed using a grid developed from a conceptual framework for QA institutionalization. This first step was followed by an analysis and summary of collected data. The PROSAF technical staff then sketched an institutionalization plan emphasizing actions to



be taken to shore up the deficiencies revealed. A list of the performance indicators was also included.

2. A plan for institutionalizing the ascendant planning process was validated during a departmental workshop during which other plans for the institutionalization of PROSAF activities had been validated. In attendance at this workshop were the MCDZS, the DDSP supervisors, the DDSP partners, and the MOH supervisors (including the DFH, the CADZS Coordinator, and the MOH Advisor for Health Service Quality).

Indicator and action summary tables were developed for tracking the implementation of institutionalization plans, including the strategic and operational ascendant planning processes. Two types of summary tables were developed. The first is directed towards the heads of service of the DDSP and MCDZS (Appendix 3), while the other is an instrument for tracking and monitoring the DDSP (Appendix 4).

Development of budget and action plans for arrondissement health centers

In order to strengthen the partnership between health center and community, PROSAF must strengthen the capacity of the COGEC and COGEA of Borgou/Alibori to participate in health issue management. Therefore, during 2004, PROSAF provided financial and technical support to the health zones of Borgou/Alibori for the development of health center action plans. The plans were developed using a process of self-assessment, which is used to determine the operational level of the Arrondissement Health Center (CSA) and the COGEAs. This activity was completed in its entirety in the health zones of Malanville/Karimama, Kandi/Gogounou/Ségbana, and Tchaourou, and will continue in the health zones of Nikki/Kalalé/Pèrèrè and Parakou/N'dali during the fourth quarter of 2004.

The self-assessment approach of the COGEAs and CSAs consists of three principal steps: preparing the self-assessment grid, completing the self-assessment, and validating the action plans. The first step aims to gather and input all of the information necessary for completing the self-assessment. The second step, which took place in 2-day workshops organized by health center, allowed budget and action plans to be developed, which were then validated during the general assembly. This action plan covers a period of eighteen months, from the second half of 2004 through December 2005. Of the total number of health zones where this activity took place, 524 people, including 123 women, actively participated in the workshops.

Self-assessment of COGEA/COGEC performance revealed that, of the seven sectors evaluated, the main sectors of underperformance in jointly managed community structures are:

i) managerial practices, ii) durability, iii) financial resources, and iv) community relations. Analysis of underperformance, which is linked to service offerings and health coverage, additionally allowed the main health problems to be identified. These problems are related to *home childbirth* (the consequences of which are neonatal and maternal mortality), the low usage rate of health centers, the low coverage of child vaccination, and the low PNC rate. A causal analysis of the entirety of these factors helped determine the necessary actions. These actions were then recorded in the action plans.

It should be noted that in all budget and action plans, community financing is planned for the funding of community activities such as the training and supervision of Community-Based Service Agents (CBSA) and the training of members of the COGEAs and the Village Health Committee (VHC).

The number of COGEAs in non-targeted zones that currently have budget and action plans is as follows:

Table 3: Number of COGEAs that have a budgeted action plan

	Malanville/ Karimama	Parakou/ Ndali	Nikki/ Kalalé/ Pèrèrè	Kandi/ Gogounou/ Segbana	Tchaourou	Total
Number of COGEAs that have an action plan	09	2	0	19	09	36
Total Number of COGEAs	09	13	33	23	06	84

Support for the development of COGEA/COGEC actions plans will continue throughout the fourth quarter of 2004, in both the former concentration zones and in the former non-concentration zones, to respond to the demand that health zones develop plans from the bottom-up.

Support for making the decentralization policy and MOH planning strategies operational.

Participation in the forum on financing basic health services in the context of the decentralization of Benin:

Beninese *commune*-level mayors, coordinating physicians, the DDSP, and numerous development partners attended this forum, organized by the MOH with the financial and technical support of PHR*plus*. Through various communication activities, debates and group work, the forum allowed:

- i) Local actors to be informed of the organization of health service provisions at the health zone level, as well as its constraints, costs, sources, and mechanisms for financing basic health services;
- ii) Discussion of *commune*'s capabilities with respect to health, and the methods for assuming responsibility for health issues in the new environment, created through reform by the field administration;
- iii) Discussion of roles of old and new actors in the financing and management of basic health services and suggestion of mechanisms for partnerships between the different institutional actors for optimal use of the opportunities created and offered by the *communes*;
- iv) Plan for *commune* involvement when financing basic health services and health interventions in the respective jurisdictions;
- v) Adapt intervention methods of the MOH, and of the community present in the *communes*;
- vi) Define involvement of *communes* in the planning, implementation, and tracking of zone health interventions; and
- vii) Specify the roles of actors in the planning, implementation, and tracking of zone health interventions.

Overall, participants were better informed of the possible outcomes of collaboration between health sector actors and locally elected representatives in the context of decentralization. At the end of the forum, the Mayors committed to allocate 5 to 15% of the local budget to *commune* health activities. They also agreed to relate the results of the forum to absent mayors and community council members under the auspices of the National Association of Communes of Benin (ANCB).

Themes developed by communications activities

- Study tour to Senegal and the justification for organizing the forum;
- Organization of the health system and decentralization reform;
- Results of the study on organization, cost, and financing of basic health services in the health zones of Bembèrèkè-Sinendé and Banikoara;
- Results of assessment of budgeting skills of communes of Banikoara and Bembèrèkè/Sinendé;
- Mutual health insurance companies (*Mutuelles de Santé*) in Benin: Situation and perspectives
- The role of communes in the creation and development of mutual health insurance companies (*Mutuelles de Santé*).
- Experience of co-financing of basic health services by USAID and local communities in Senegal.
- Opportunities for decentralized cooperation

The possible outcomes and interest in this forum for PROSAF

- This forum was a place for locally elected representatives and communities to share their experiences in managing health problems in the target zones.
- Ascendant planning was recognized by all as being an appropriate method for facilitating the participation of locally elected representatives and the people in the management of local health services.
- The involvement of locally elected representatives strengthens community participation. These leaders mobilize financial resources for health through local budgets or mutual health insurance companies (*Mutuelles de Santé*). This will contribute to the sustainability of actions begun with PROSAF support.

During the presentation of group work, the following statement was made by a mayor participating in the forum: *We, the locally elected representatives, are in favor of the ascendant planning model presented by the PROSAF representative. This model fully associates the communities with us, the local leaders. At least this model gives us the opportunity to no longer be pushed aside by those governing the health sector in our communities. It also comes fully within the decentralization context.* (Mayor of Banikoara.)

Participation in the work sessions of the Program Planning and Integration technical Sub Committee (part of the Committee for Tracking the Recommendations of the Forum on Decentralization and the Health Sector).

PROSAF supported the MOH in its efforts to find a better planning strategy through work sessions on program planning and integration. The terms of reference (TDR) for these work sessions were: i) the updating of texts regarding the roles, responsibilities, and function of each level of the health pyramid; ii) the restructuring of the MOH, in particular at the departmental and central levels, to adapt it to the operational demands, which in turn result in health system decentralization reform; iii) creation of a framework for consultation for the integrated implementation of programs at the operational level. These TDR were developed from issues raised during the forum on health system decentralization. These issues are: incorrect assignment of roles, responsibilities, and prerogatives at the different levels of the health pyramid; inadequate structure of the MOH and the DDSP for reform at the base of the health pyramid; the strongly centralized execution of programs which, contrary to the spirit of reform, have not been integrated.

During the work sessions, the current MOH methods (at the time of writing) were reviewed in comparison to the issues raised. Key documents thought to be helpful in shedding light on these issues

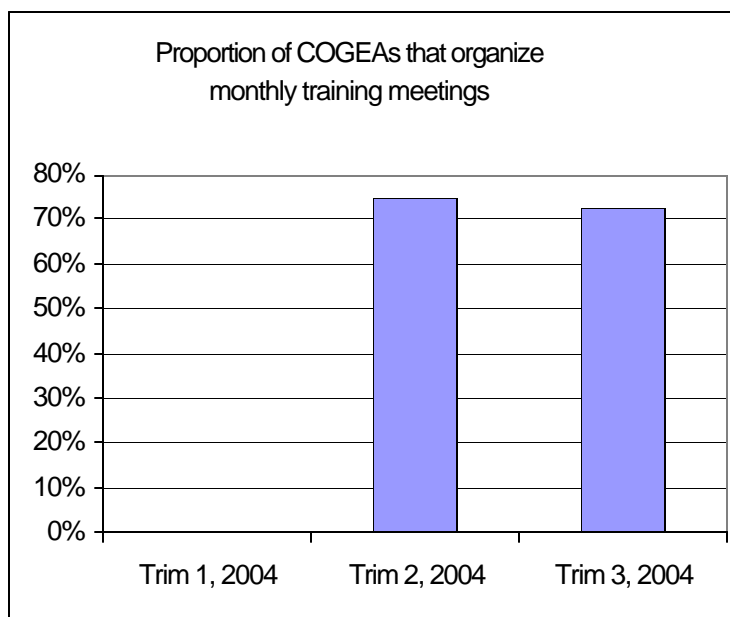
were reviewed, with the goal of making them available to each member of the sub-committee. Two working groups then analyzed the texts. The texts were first analyzed with regard to the roles and

responsibilities of the different levels and with respect to the structure of the departmental and central levels. They were then analyzed for the current practices at the MOH level in planning and implementation of activities. To share the experiences currently taking place in Borgou/Alibori, the DDSP/BA gave a presentation on the experience of implementing ascendant planning with PROSAF support. The PROSAF representative presented proposals for coordinating action plans at the departmental level through participation of the different partners and the central programs. The different working groups will present their work in the fourth quarter so that the MOH office can develop legislation from the completed technical analyses.

2.1.3 Intermediate Sub-Result 1.3: Community participation in the health sector has been achieved

Monthly training meetings are held by the health centers and the COGEAs/COGECs

Throughout this year, directors of Community Mobilization/Behavior Change Communication (CM/BCC) tracked the occurrence of monthly COGEA meetings at each health center. At the beginning, the monthly meetings were not regularly held in the five non-concentration zones. COGEA functions in these health zones are limited to cash-flow activities that are handled by the presidents and treasurers. The community partnership self-assessment process permitted the COGEAs to develop action plans that integrate monthly training meetings. The implementation of this plan should permit COGEA performance to progressively improve in this area.



During the 2nd quarter of 2004, 75% of the COGEAs of Borgou/Alibori regularly held legislative meetings. During the 3^d quarter, this performance was somewhat lower at 73%, due to the replacement of COGEA members. Placement of new COGEA members is to begin in certain health zones during the 4th quarter, which may boost this performance. A checklist has been developed by the directors of social mobilization and behavior change communication in order to facilitate the coaching of COGEA members during these monthly meetings.

A mechanism for planning, coordinating, and supervising basic community health services is institutionalized at the DDSP level and in the seven health zones.

PROSAF supported the development of a plan to institutionalize the coordination and supervision of community-based services (CBS) in the seven health zones. It was suggested that each health zone complete a self-assessment exercise. This self-assessment was completed at the health zone level by the HZMT of each zone. In a self-assessment grid, the HZMT described its current situation relative to the desired situation, identified the gaps to be filled, and planned the actions that would close those gaps. The grid consists of eight components identified as the criteria for institutionalization and five stages within each component. These are the stages for all institutionalization processes. Each HZMT analyzed its

own situation by identifying the stage they currently attained with respect to each of the eight components. At the end of this analysis, a plan for institutionalizing the coordination and supervision of the community-based services of each health zone was finalized and validated during the departmental workshop.

To develop the capacity of community mobilization supervisors it is important that, on the one hand, community-based activities be included in the DDSP and health zone supervisory and monitoring guides, and on the other hand, that community-based services be included in the job descriptions of health center personnel. The table below shows the performance of the health zones in this area.

Table 4: Health zones that include community-based health services in their supervisory tools and in the job description of health workers.

	Bembèrèkè/ Sinendé	Banikoara	Malanville/ Karimama	Parakou/ N'dali	Nikki/ Kalalé/ Pèrèrè	Kandi/ Gogounou/ Segbana	Tchaourou	Total
CBS activities included in the HZMT supervisory tools	1	1	1	0	0	0	0	3
CBS activities included in the job descriptions of health workers in Community Health Centers (CSC) and Sub-Prefecture Health Centers (CSS)	1	1	1	0	0	0	0	3
HZMT Performance (all criteria fulfilled)	100%	100%	100%	0%	0%	0%	0%	43%

The performance level stayed at 43%, or rather three (3) health zones out of seven (7) participated, from the second quarter of 2004. This process will continue in the other health zones with the effective launch of the community IMCI.

The COGECs of non-targeted zones are trained to advocate for health issues, including preventive measures.

The self-assessment completed by the COGEAs in Borgou and Alibori revealed the need for health advocacy training. The training module is currently being developed. Training is included in the COGEAs' 2005 action plans.

Support for the replacement of COGEAs in Borgou/Alibori

The self-assessment completed by the COGEAs showed that multiple functions and the non-replacement of members at the end of their term are among the reasons for dysfunction. To facilitate activities, a

ministerial order¹ was executed that provided internal by-laws for the Arrondissement Health Center Management Committees. The order also modified the structure of the COGEAs in order to adapt them to the context of decentralization which took place in 2003. Therefore, in accordance with this order, the HZMTs proceeded, with the technical assistance of PROSAF, to replace 91 out of the 109 COGEAs in the Borgou/Alibori. This replacement created a need for strengthening the capacity of new members, so that they are fully able to carry out their responsibilities. The replacement took place in accordance with the statutes and internal by-laws of the COGEAs. All members having already served two consecutive terms have been replaced. The 18 other COGEAs will be replaced during the fourth quarter.

Training COGEAs in their roles and responsibilities and in management and management assessment

After the renewal of the COGEAs, training programs began in order to strengthen new members' capacity to properly carry out their mission. Training took place in the health zones of Kandi/Gogounou/Ségbana and Banikoara. The general goal was to present some basic concepts and the foundations of national health policy to the members of the Managing Committee. More specifically, the following took place:

- Explanation of Primary Health Care (PHC) and the different strategies for its implementation;
- Presentation of goals and strategies for national health policy and explanation of the different levels of the Benin health pyramid;
- Explanation of the principles of community participation, joint management and its different bodies;
- Reminder of the roles and responsibilities of the different joint management actors;
- Presentation of the job description of each COGEA member;
- Determination of the principles of good COGEA operations;
- Determination of the principles of teamwork and its manifestations at the Arrondissement Health Center (CSA) level.



Overall, 212 members of 30 COGEAs from the two health zones took part in these training programs, which were made possible by members of the HZMTs, with PROSAF's financial and technical support. In the health zone of Kandi-Gogounou-Ségbana, financing was made possible by the PBA.

Furthermore, the health zone of Banikoara organized COGEA member training in material, accounting, and financial management of the health center. This training program, which brought together COGEA presidents, secretaries, and treasurers (28 participants in all) aimed to develop the capacity of the different actors in co-management of the health centers, and to ensure the management and oversight of the health centers. The topics of note were:

- Clarification of management procedures regarding medication and financing in arrondissement health centers (CSAs);
- Orientation of participants in the use of different accounting tools;
- Determination of the different rules to follow to ensure good qualitative and quantitative management of medication;
- Orientation of participants in assessment of medications, financial, and budget management;

¹ Order No. 6723/MSP/DC/SGM/CT/DIVI/DNPS/DNPEV-SSP/CADZ/SA

At the end of this training program, participants had identified the assessment and management tasks for which they are responsible (but were not previously aware of), and had integrated them into their CSA action plans.

2.1.4. Sub-Intermediate Result 1.4: Strengthening partner coordination and collaboration

Coordination and collaboration with the MOH

At the central level, PROSAF, in addition to having several meetings with the committee for tracking the recommendations for MOH decentralization, had several consultation meetings with the CADZS, the DDP, the DRFM, and the DFH. PROSAF lobbied the DRFM and the DPP for MCDZS responsibility for the management of funds designated for the health zones, in order to facilitate the implementation of activities at the health zone level. Moreover, PROSAF lobbied for members of the HZMTs to be trained in financial management.

Furthermore, PROSAF participated in meetings and workshops such as:

- Workshop for reporting on PNLs documents, among them the report concerning results of 1) the 2002 national study on HIV seroprevalence and 2) report concerning the strategies, norms, and procedures of Behavior Change Communication.
- Negotiation meeting on “manuals for treating neonatal and obstetrical emergencies” at the Lagune de Cotonou Maternity Hospital. PROSAF met with the director of this maternity hospital in order to negotiate PROSAF access to materials. 16 manuals on EONC were prepared under the direction of the maternity hospital technical staff and will serve as training materials for workers in the Zone Hospitals of Borgou/Alibori, as part of the EONC collaborative model. The director agreed to issue these manuals at the promotional price of 2000 FCFA per manual.
- Lobbying to DFH, DPP, and CADZS regarding (i) the importance of the partners meeting concerning the establishment of health zone warehouses in Borgou Alibori, planned to be held in Parakou on Wednesday, October 6, 2004, (ii) the importance of their participation to the success of this meeting. All institutions approached applauded the initiative of this meeting and reassured PROSAF that they would attend.

PROSAF conducted intense consultation activities with the CADZs, the DRFM, the DPP, and the DFH during 2004 to strengthen the capacity of the MCDZS to better plan and manage health services. All these activities bear witness to the level of technical collaboration established between PROSAF and the MOH. This relationship will continue to be strengthened during the 2005 year.

This successful cooperation was crowned by PROSAF's financing of the participation of the MOH (through the DFH), and the DDSP of the departments of Borgou and Alibori, at the Global Health Council conference, which took place in Washington in July 2004. This was an opportunity to have work sessions with the technical staff of USAID/Washington who are interested in the health program in Benin, and to meet the former director of USAID/Benin, Mr. Harry Lightfoot, currently posted in Washington.

Collaboration with USAID/Benin

Meetings with the USAID Family Health Team

Several meetings were held this year with the USAID Family Health Team. The first meeting concerned contract review (post-award conference), which allowed the terms of the PROSAF *Transition Phase* contract to be clarified and the levels of certain indicators to be adjusted.

The second meeting consisted of a review of the activities contained in the 2004 PROSAF-*Transition Phase* work plan (Activity Implementation Review) to assess the degree of completion of these activities, and to identify the major difficulties encountered when these activities were implemented in the field. These exercises allowed the Family Health Team to see the contribution it can make in facilitating the implementation of field activities through political dialogue with the MOH.

The third meeting was held to discuss PROSAF budget distribution in accordance with the source of funds allocated by USAID to PROSAF during the 1st and the current contract (PROSAF *Transition Phase*). Although it appears easier to disburse the funds in accordance with the source of funds for the current contract, this was not the case for the previous contract, given the number of CLINs contained in the budget, and the numerous modifications made during the execution of that contract

USAID/Benin health partners meeting

This meeting enabled different projects financed by USAID/Benin to discuss difficulties regarding planning and implementation of plans developed with the partners (the health zones, the DDSP and the technical and central directorates of the MOH). The following groups attended the meeting: URC-PROSAF, PSI, PROLIPO, CRS, INTRAH/PRIME, JHPIEGO, PHR^{plus}, BHAPP, the DDSP/Borgou/Alibori, the DPP and the family health team members. The different partners presented the activities completed from October 2003 to June 2004 and discussed both the difficulties encountered and suggested solutions.

The discussion focused on the following points: i) staff mobility; ii) the low per diem rates paid to government workers; iii) the need for increased supervision by the DDSP; iv) sustainability of the intervention project and v) collaboration between family health team partners. The exchanges between the different partners on each subject allowed the issues brought forth to be clarified and concrete proposals to be made. As far as per diems were concerned, it was recommended that an analysis be conducted of the different per diem rates practiced by each partner as compared to the standard of living in each locality of the country, in order to make recommendations to USAID. The formula practiced by PROSAF for allocating per diems to its staff could serve as a model.

It is important to emphasize that the DDSP of Borgou/Alibori dispatched a representative to this important meeting and ensured that this issue would be addressed.

Presentation on PROSAF (first phase) results and on the execution of PROSAF-Transition Phase to the new USAID/Benin Director

The goals, strategies, and results of the activities executed by PROSAF from January 1999 to December 2003 were reviewed. Additionally, the challenges faced by the staff were discussed, and suggestions and solutions were formulated. The second part of the presentation discussed the goals, methodology, practical organization, and implementation of PROSAF *Transition Phase*, in addition to examining the achievement level of activities by looking at the performance indicators. Pertinent questions raised by the new director were answered with precise and clear responses from the PROSAF team, allowing him to better understand the program.

Participation in the USAID Family Health Team meeting on CAME decentralization

The meeting was held at one of the USAID offices. The institutions represented were: PROSAF, PNUD, CAME, Cotonou, DPED/MOH, Swiss Cooperation, French Cooperation. The aim of this meeting was to discuss and clarify the TDR, developed by USAID, for the feasibility study on the decentralization of the CAME management system, so that a common understanding of these TDR be reached before they were finalized and consultants recruited. The head of the USAID Family Health Team presented the context for the study and its goals and was insistent on the fact that if the Parakou trial warehouse succeeded, that this model would be transferred to other departments. The DPED clarified the position of the MOH;

specifying that the spirit of decentralization is the de-concentration of the responsibilities of management and not the creation of a CAME-extension. The other institutions represented recognized and accepted the relevance of this feasibility study, which will provide the support necessary for the installation of departmental warehouses in other regions of the country. PROSAF took advantage of the opportunity to inform participants about the partners meeting (planned to be held in Parakou) on the establishment of health zone warehouses in Borgou/Alibori.

Collaboration with PHRplus

2004 marked the strengthening of the collaboration between PHRplus and PROSAF, in both administrative and technical planning.

Administrative plan:

With the aim of facilitating PHRplus' fieldwork, PROSAF *Transition Phase* transferred one of its vehicles to PHRplus. This facilitated movement in the field. In the Borgou/Alibori, PHRplus tracks the progress of *Mutuelles de Santé* activities in Bembèrèkè/Sinendé and Banikoara. Moreover, an office was made available to PHRplus in PROSAF *Transition Phase* building to facilitate transportation to and from the PHRplus office in Cotonou.

PROSAF *Transition Phase*, which does not have an-office in Cotonou, frequently uses PHRplus services in times of need.

Technical plan:

Choice of sites for PHRplus -supported *Mutuelles de Santé* activities

Given the enormous results in terms of mobilization and community participation recorded in the two PROSAF concentration zones, Banikoara and Bembèrèkè/Sinendé, PROSAF-*Transition Phase* determined that *Mutuelles de Santé* activities financed by USAID Benin should take advantage of these results in order to maximize their chances for success. PROSAF recommended that PHRplus conduct its activities in these two health zones. The feasibility studies and the preliminary activities conducted confirmed the analysis of PROSAF technical staff. This contributed to an increased degree of technical collaboration between these two programs, which already work together.

Participation in the work of the sub-committees for tracking the implementation of recommendations of the Forum on Decentralization.

PHRplus was mandated by USAID/Benin to support the MOH in its decentralization efforts and carried out the role of providing technical support to the MOH management of activities related to decentralization of the health system while taking into account the decentralization of the administration. PROSAF, from its field experience in Benin, made suggestions for carrying out decentralization activities, particularly in the realms of planning and decentralized management of the health system. The participation of PROSAF *Transition Phase* in the different decentralization activities was described above.

Preparations for the workshop on health financing as part of the decentralization planned by PHRplus in August 2004.

A work session consisted of analyzing the possibilities for collaboration between PROSAF achievements and the PHRplus interventions in the former non-concentration zones. The activity-planning model supported by PROSAF was presented during the workshop with a view to eventually adopting this model for planning *Mutuelles de Santé* activities.

This forum was successfully held and is described above in the section "ascendant planning process."

The collaboration, which began this year between PROSAF *Transition Phase* and PHRplus, is cited by USAID/Benin Family Health Team as a model to follow for achieving the collaborative framework sought by USAID at the partners level.

Collaboration with Plan Benin

During this year, PROSAF received a visit from the director of the Nutritional and Food Practices division of PLAN BENIN who stayed in Parakou for a week to meet with PROSAF and MCDI. During this stay, several meetings were organized to discuss intervention approaches at the community level of the three institutions. Visits to field activities sites were also completed.

Collaboration with MCDI

As part of the implementation of the project CHILD SURVIVAL, MCDI and PROSAF signed a memorandum of understanding (MOU) regarding implementation of community activities; such as the installation of CBSA and IMCI-C in the communes of Tchaourou and N'dali. PROSAF will support strengthening health worker capacity so that health services, particularly those that are community based, may be better managed, and will finance all activities regarding participatory community assessment and the recruitment of CBSAs. Following the *Transition Phase* of PROSAF, MCDI will take over, financing CBSA training and facilities.

Notably, MCDI established a team of instructors at the level of the health zones. This team's principal goal is to revise and authorize CBSA and VISA Mothers (mother who are selected within their community to coach other mothers on VISA techniques) training modules. The team unites the supervisors of the two health zones, the DDSP, and representatives from partners intervening in these zones.

Collaboration with the Swiss Health Project (PSS)

PROSAF *Transition Phase* and PSS strengthened their collaboration this year through several activities ranging from planning activities of common interest to technical meetings for implementing activities. After presenting its work plan to PSS, the two programs met to discuss the implementation of community mobilization activities - particularly co-management, which highly interested PSS, and communication for behavior change, for which PSS provides financial support and PROSAF *Transition Phase* provides technical support.

As part of its BCC activities, PSS participated in the recruitment of AIDS education facilitators and financed the implementation of AIDS awareness through a curriculum developed with the technical support of PROSAF *Transition Phase*. As part of the implementation of the EONC and IMCI collaborative networks, PSS worked with PROSAF *Transition Phase* on the technical aspects and supported the implementation of the networks in Zou/Collines. The two programs jointly organize a workshop on QA, and share the necessary technical information for the networks' success.

Participation in the workshop for analyzing referrals and counter-referrals in the PSS-supported health zones of Dassa.

The goals of this workshop are: i) to evaluate the analysis report on referrals and counter-referrals of each health zone, ii) share the results and difficulties of each health zone with respect to referral and counter-referral analysis, and ii) help the health zones, as much as possible, overcome the remaining difficulties.

During the next year, the two programs will work to create conditions conducive to the continuation of PROSAF activities in the PSS-supported health zones after the PROSAF *Transition Phase* has ended.

Collaboration with ABPF

Two main meetings were held this year with the ABPF.

As part of ABPF restructuring, a provisional administrator was designated by the IPPF. PROSAF was one of the ABPF's main partners and, in conjunction with the existence of a new contract between the two institutions; the provisional administrator requested a work session. During this session, which the programs director attended, the following took place:

- Inform the provisional administrator of the goals of PROSAF I and the *Transition Phase*
- Review questions arising from the previous contract
- Discuss the content of the new contract signed between ABPF and URC as part of the implementation of PROSAF *Transition Phase* activities
- Clarify PROSAF's goals vis-à-vis those of the ABPF and URC, as well as the communications methods to use in order to facilitate seamless communication.

This work session allowed the provisional administrator to better understand ABPF management, as well as ABPF's efforts to respect its commitments within the framework of the new contract with URC.

The PROSAF Coordinator called a work session and met with the accountant and programs director to facilitate the ABPF administrative team's understanding of the management procedures of the contract with URC. This meeting assessed the execution level of the ABPF subcontract and reviewed the content of the accounting sheets required for requesting funds. This meeting allowed the two members of the ABPF administration to better understand the role of different management tools used as part of this subcontract, and above all to better understand the contract's use. This will allow the previously noted delays with respect to submitted ABPF fund requests to be avoided in the future.

Collaboration with Intrah Health International

This collaboration resulted in a CD containing the revised modules on family health protocols. This allowed PROSAF *Transition Phase* to copy them and begin the training of 850 health workers (including nurse's assistants) in Borgou/Alibori on its revised protocols.

Intrah Health contributed to the community EONC-training of CBSAs of the health zone of Malanville/Karimama.

Collaboration with the UNFPA

PROSAF participated in the workshop on the results of the evaluation of the security system for family health products, organized jointly by the UNFPA and the DFH-MOH. During this workshop, the process of integrating contraceptive products into the generic essential medications was also reviewed. It came to light that the situation has not progressed since condoms were made available to CAME. Many efforts and steps remain for the partners at the central level for this integration to become a reality. As part of the establishment of distribution warehouses in the health zones of Borgou and Alibori, PROSAF also had many advocacy sessions with the supervisor of the UNFPA programs. These sessions concerned obtaining the participation of UNFPA in financing the establishment of zone warehouse facilities, beginning with their participation at the partners meeting on this topic. UNFPA recognized and applauded the efficaciousness of PROSAF leadership in strengthening the safety of family health products and would like for this close collaboration continue in 2005.

The team of the decentralized office of UNFPA in Parakou, led by its coordinator, made a courtesy visit to PROSAF during which it presented its goals, strategies, and activities as well as its intervention sites. PROSAF took advantage of this occasion to review current activities in Borgou/Alibori with respect to the safety of contraceptive products and essential medications, as well as the implementation of strategies

such as EONC. The two partners agreed to combine their efforts to ensure the continued supply of contraceptives and the availability of EONC, Caesarian kits, and other required materials.

Coordination and collaboration at the departmental level

PROSAF coached the DDSP to remind the central level of the necessity of taking DDSP planning into consideration. Furthermore, it had several work sessions with the DDSP.

The following points were discussed:

1. Organization of a donor's meeting about the financing of the zone-level distribution warehouses in the Borgou/Alibori. Experiences were shared regarding the establishment of warehouses in Banikoara and Kandi. The donor's meeting was scheduled for October 6 and the DDSP and the PROSAF Chief of Party agreed on its location, as well as on the list of MOH supervisors and the donors to be invited.
2. The contribution of COGEC/COGEAs to the financing of training activities for COGEA and CBSA members. Thinking in terms of sustainability, PROSAF expressed the need for this contribution to be made for future CBSA training activities. The DDSP will instruct the MCDZS to this end during the meeting for the health worker transfer.
3. Rendering operational the administrative acts contained in institutionalization plans that were adopted by consensus (with the participation of MOH representatives). The DDSP would like PROSAF to support the DDSP in drafting these administrative acts. The PROSAF technical team will work on these texts so that they can be made available to the DDSP as soon as possible.
4. The need to find a solution to the repeated postponements of the training of MCDZSs and their supervisors in human resource management, teamwork, and leadership. Training was postponed several times because of MCDZSs' unavailability during the third quarter due to involvement in other activities. The DDSP promised that this training program would be conducted at the end of November/beginning of December, depending upon the implementation of the next national vaccination days.

As the Malanville health zone was accepted as the experimental site for implementing the 6-day training model on clinical IMCI, the DDSP and the PROSAF Chief of Party took a joint trip and met the HZMT members of each health zone in order to inform them of this proposal and gain their support. The HZMT greatly welcomed the news and wished that all terms be finalized so that this zone does not lag behind the other six health zones of Borgou/Alibori. Starting in January 2005, the activities for implementing this short-term IMCI training formula will begin in order to allow enough time to ensure performance tracking and evaluation of trained agents before the end of PROSAF *Transition Phase*.

2.2. Intermediate Result 2: Access to family health products and services is achieved.

These PROSAF-*Transition Phase* results correspond to USAID/Benin Intermediate Result 2, “Increasing access to services and products.” The principle activities of these results include: strengthening the product supply and distribution system, improving the integrated family health services offer, and increasing the availability of services and products at the community level.

This year PROSAF continued its efforts to increase access to family health services, emphasizing:

- Development and distribution of the plan institutionalizing the integrated services offer.
- Training of all providers in the seven health zones in the integrated family health services offer.
- Making more active the process of establishing zone distribution warehouses as well as HZMTSS’ coaching and supervising of providers in logistics management.
- Continued strengthening and development of community based services (CBS) through

Primary Accomplishments

- Plans developed for institutionalizing integrated family health service delivery in public and private health structures.
- Experiences documented of establishment of warehouses in the zones of Banikoara and Kandi.
- PIPELINE software program for managing family health products and needs projection installed in the seven health zones.
- An evaluation grid for rating excellence of family health integrated services in health centers was developed.
- 22 family health product supervisors and management supervisors from the CSCs, health zones and zone offices of 7 health zones trained during 2 days in the use of PIPELINE software.
- 146 healthcare providers, (among them 75 Nurse’s assistants), from the health zones of Parakou N’dali and Banikoara were trained in the family health integrated services offer.
- 23 ENIAB instructors were trained in the family health integrated services offer during 5 days.
- 38 Memorandums of Understanding (MOUs) were signed between 38 Arrondissement Health Centers (CSA) and the villages of their “aires” of health. Participatory community-level assessment completed in three health zones.
- Supervision of CBSAs.
extension into non-targeted zones.

2.2.1. Sub-Intermediate Result 2.1: The departmental logistics management and distribution system is improved in Borgou/Alibori

Support of the DDSP and health zones in creating health zone warehouses.

PROSAF provided support at two levels by supporting the documentation of the experiences of establishing zone warehouses in Banikoara and Kandi, and lobbying to potential partners at the central level.

PROSAF coached the ad hoc committee established by the DDSP to document the current experiences of the zone warehouse in Borgou/Alibori. Two trips to the field were completed, to observe the two

experimental warehouses and to talk with the principle actors managing them. The information collected in the field and the information taken from available documents was then analyzed following a work-plan proposed by PROSAF. This process culminated in a document that comparatively and analytically describes the two experiences and as the principal lessons learned and to be applied in the creation of health zone warehouses in Borgou and Alibori.



Discussion with the Banikoara zone warehouse manager.

While these experiences were being documented, PROSAF identified and met with some potential partners who may be interested in participating in financing the implementation of the zone warehouses. They were World Bank, USAID, CAME Cotonou, and the MOH. Emerging from the different discussions was the discovery that establishing health zone warehouses is a priority shared by all. World Bank may add it to its program if the need is formally expressed as a priority by the MOH. The Prospective and Strategy Study Service of the DPP-MOH committed to establish a file on this issue. CAME Cotonou is in favor of providing the initial grants in the form of family health products, ensuring the training internships of health zone warehouse managers in Parakou and Cotonou, making management tools available, and ensuring that norms be respected with regard to building arrangement and location before bringing in the stock. The USAID Family Health Team has already planned a feasibility study on the decentralization of the family health product supply system and in particular that of the management of the regional warehouse of Parakou. The results of this study will serve as input for analyzing the financial and technical feasibility of establishing zone warehouses. These expressed intentions and initiatives bode well for an environment that is in favor of establishing health zone warehouses. Progress should be tracked attentively by PROSAF and the DDSP B/A during the months to come.

Terms of Reference (TOR) for a feasibility study on the decentralization of CAME management

At the request of the USAID health team, PROSAF reviewed the TDRs of a feasibility study it planned to carry out on the decentralization of CAME management. The goal was to understand the conditions under which supply management and family health product distribution to the departmental warehouse could be decentralized and made participatory, in order to better contribute to improving people's health.

After this TDR review, (to which other partners of the USAID health team contributed), PROSAF participated in a USAID health team meeting on the decentralization of CAME. Please refer to sub-IR 1.4 for a detailed discussion of this meeting.

Lobby partners of the MOH and the DDSP BA for the establishment of health zone warehouses.

PROSAF took advantage of the opportunity of the presence of the Director General of CAME in Parakou (present for the launch of the expansion of the departmental warehouses) to discuss the documented experiences of the health zone warehouse in Banikoara and Kandi, as well as the development of the health zone warehouse installation process in Borgou and Alibori. The Director General of CAME reaffirmed the commitment of CAME to: i) pre-finance and establish initial stock, ii) lend its support in the recruitment and training of managerial staff in the health zone warehouses; and iii) support strengthening HZMT and health zone supervisors with respect to family health product management. Following this discussion, the two speakers agreed to meet with the DDSP/BA to request not only its support in extending departmental warehouses, but also its leadership in the re-launch and execution of the health zone warehouse installation process. The session with the DDSP/BA resulted in the decision to organize a meeting with DDSP/BA partners interested in health zone warehouse installation in the Borgou/Alibori, which was planned for October 6, 2004 in Parakou.

Additionally, PROSAF attended the USAID meeting on the TDR of the feasibility study on the decentralization of CAME management to meet with partners such as UNICEF, FNUAP, DPED/MOH,

and DFH/MOH. Advocacy concerned: (i) the importance of the partners meeting planned to be held in Parakou on the establishment of health zone warehouses in BorgouAliboi, (ii) the importance of their participation to the success of this meeting. All institutions involved in the meeting supported the initiative of this meeting and reassured PROSAF that they would attend.

Strengthen management of logistics system.

Acquisition and installation of PIPELINE software

PROSAF supported the DDSP in installing PIPELINE software in its health facilities to strengthen the management capabilities of the HZMT logistics system. The team that installed the software consisted of a PROSAF representative, two DDSP Service Directors, the Research, Planning, and Documentation Service (SEPD) and Diagnostic Exploration and Pharmacies Service. Seven health zone offices, six zone hospitals, three *commune* health centers, four departments of the DDSP and the Departmental Hospital center currently have this management technology available.



Installation of PIPELINE software on the computer of a supervisor-accountant at the zone hospital of Malanville by the C/SPED (seated) with the C/SEPD and the supervisor



Orientation of Chief Physician at the zone hospital of Malanville in the use of PIPELINE by the C/SEPD

In each health zone, all HZMT members present benefited from a briefing on use of the software - launching and accessing the different menus. PIPELINE allows managers and accountants of the health zones, Departmental Hospital Center, and the DDSP to computerize their management procedures, and especially to project the needs of the health zones and the DDSP for family health products.

This is consistent with the new policy for contractualisation that CAME Cotonou seeks to establish with the health zone and the DDSP in order to make supply better correspond to demand.

Training of health zone supervisors and accountants in the use of PIPELINE software

Twenty-two (22) supervisors and family health product supervisors from the *Commune Health Center*, health zone, and zone offices came from seven health zones to attend a two-day training in the use of the PIPELINE software. This training session was facilitated by the C/SEPD and C/SPED of the DDSP.

The goal of the training was to improve health product management in the health facilities by familiarizing supervisors with the Information and Logistics Management System, and training them in the use of PIPELINE software. The first day was devoted to an orientation on the Information and

Logistics Management System (SIGA) and the use of menus, and functions, as well as the limitations of the PIPELINE software. During the second day, representatives from each health zone input their data into PIPELINE to learn how to track stock and supplies, generate forecasts, and graph both forecasts and results.

At the end of the training, the trainees requested that the DDSP and PROSAF regularly track their progress, so that the use of PIPELINE is effective in all health zones and serves to improve family health product management performance.

Post-training follow-up visit

This follow-up visit was conducted in the health zones of Nikki/Kalalé/Pèrèrè, Parakou/N'dali, and Kandi/Gogounou/Segbana. The trained supervisors and accountants had effectively begun using PIPELINE in the zone offices of Parakou/N'dali and Nikki/Kalalé/Pèrèrè, using the instruction received at the time of training. However, they had difficulties making graphs and swing curves of actual and planned demand. At each request the software generated “shifted” graphs that did not allow for an analysis of all of the trends. Use of the software has not yet begun in the health zones, nor at the office of the zone of Kandi. At the Boko hospital, the software has not yet been installed, while in Nikki and Kandi the work overload prevented trained supervisors from using it. PROSAF, along with C/SPED and C/SEPD trainers will provide coaching to the health zones to allow them to better use PIPELINE. Health zone mastery of this important tool for family health product management is essential if the health zone warehouses that MOH intends to establish in the health zones are to become a viable option.

Performance in Managing the Ordering of Family Health Products

PROSAF continued quarterly performance monitoring of the health centers' logistics management in collaboration with the SEPD/DDSP and the health zone statisticians.

Health Center performance is measured by two criteria: 1) accurate estimation of the quantity of family health products to be ordered and 2) sending order forms before inventory shortage. A Health Center is judged to be performing when the two criteria are met. Performance for this year is presented in the table below.

Table 5: Service providers who correctly estimate and submit order forms for key family health products on time

Health Center Performance

Performance Indicator	1st Quarter 2004 (105 Health Centers)	2nd Quarter 2004 (107 Health Centers)	3rd Quarter (105 Health Centers)
Correctly estimate their needs	62	69	75
Submit order forms with enough time before inventory shortage	99	176	105
Management index of family health product orders	59%	64%	71%

Health Center performance of the management of family health product orders improved throughout the quarters. As the above table shows, it went from 59% in the first quarter of 2004 to 71% in the third quarter of 2004.

Only the health zone of Nikki/Kalalé/Pèrèrè continued having difficulties in this area, probably because supervision fell by the wayside due to the struggle against the cholera epidemic (as was instructed by the DDSP/BA). As the supervisors and accountants of all of the health zones have been trained in the use of PIPELINE software, it is not unthinkable that acquiring this new skill will certainly contribute to raising the performance level of Nikki/Kalalé/Pèrèrè.

2.2.2 Sub-Intermediate Result 2.2: Improve integrated offer of family health services.

Throughout the year, PROSAF has emphasized both institutionalizing family health integrated offer of services through developing and implementing an institutionalization plan, and through extending integrated services delivery to the health centers of the seven health zones of Borgou/Alibori.

Expanding the availability of integrated family health services.

Training the providers of the seven health zones, including nurse's assistants, in integrated offer of family health services, along with the use of revised family health protocols.

With regard to extending integrated offer of services to the health centers, PROSAF had a work session with the integrated offer of services focus groups in each health zone. The discussion concerned, on the one hand, the integrated offer of services training mechanisms for all qualified health workers and all nurse's assistants, including workers newly appointed in the health zone. In addressing this subject, the different approaches for efficient and rapid transfer of capabilities (such as tutoring, site training, peer coaching and supervision) were reviewed. Each health zone will have to submit its integrated offer of services training plan to the DDSP and to PROSAF. Similarly, PROSAF determined with the focus groups that a health center of excellence in integrated offer of services practice would be identified, and then strengthened in order to serve as a model in each health zone. The health workers of other health centers will come to learn the organization and practice of integrated offer of services at these centers of excellence.

To this end, PROSAF developed an evaluation grid for rating excellence of a health center in integrated offer of services. This grid is currently being validated by a group of three health zone coordinating physicians, two chief *commune* physicians, the DDSP integrated offer of services focus group, and by the PROSAF technical team. Each health zone used the validated grid to identify its health center of excellence in integrated offer of services.

PROSAF also provided financial and technical support to the health zones in preparing and conducting provider training in the seven health zones, both in integrated offer of services and in the use of family health protocols. PROSAF simultaneously sought to integrate the transfer of capacity, particularly when target audience was the same, while carrying out a real learning process through the training activities led by the health zone training teams. The training was organized into the following two main stages:

Planning and conceptual meeting

This session allowed for the clarification of the training content (for the integrated offer of health services and revised family health protocol), the target audience (nurses, midwives, nurse's assistants of health centers and health zones), the period (September), the duration of each training session (3 days), the roles and responsibilities of the HZMT (practical organization of sessions in the field, addressing per diem issues of trainers and transportation fees of participants), the DDSP (supervision) and PROSAF (coaching training teams at the time of preparation and development of sessions). The maximum total number per session was also discussed and capped at 24 providers.

Negotiation with each HZMT for a period during which the health zone training team's only responsibility will be the training sessions.

Development and distribution to the health zones of generic reference documents, such as the trainer's guide (derived from a document developed by the health zone of Parakou/N'dali), the provider guide (derived from a document developed by the health zone of Banikoara), guide to the standard program format, including how a session is developed, and the case studies list. It is hoped that these reference documents will motivate each of the health zones to develop their own teaching documents.

Coaching the health zone training teams on how to adapt educational content to focus on areas of under-performance, finalize teaching documents and sample exercises, apply information to real situations, and choose case studies.

Generally, a three (3) day training session is structured in the following way:

The first day is devoted to clarifying concepts using examples taken from the daily practice of the health center providers and the family health protocol lecturing technique. During the second day, case studies are practiced through group work and role-playing. The third day addresses concrete cases practiced by the students in a health center, during which they receive immediate feedback from facilitators, and learn concrete actions to be taken when they return to their posts.

As of the end of September 2004, 146 providers, including 78 nurse's assistants, in the health zones of Parakou/N'dali and Banikoara were trained in integrated offer of services and the family health protocols. All other health zones programmed their training sessions for the fourth quarter of 2004.

Institutionalizing the Integrated Offer of Family Health Services

Developing and implementing the integrated offer of services institutionalization plan

This year was devoted to developing a plan for the institutionalization of the integrated offer of family health services in the public and private health facilities of Borgou/Alibori. This plan was developed according to the following stages: i) consensus between PROSAF and the DDSP technical staff on the conceptual framework of integrated offer of services institutionalization, and on the tools for assessing the current level of institutionalization in the health zones and DDSP; ii) self-assessment of the level of institutionalization obtained at the DDSP, conducted by the heads of departments, and of each health zone, conducted by the HZMT; iii) analysis of the results obtained by the PROSAF technical staff, and development of the integrated offer of services institutionalization plan for all of Borgou/Alibori. This plan was developed along the following axes: Leadership, Policies, Fundamental Values, Organization, Information/Communication, Resources, and Incentives. Actions to support and improve integrated offer of services at the DDSP and health zone levels have been integrated into the plan according to these different axes; and iv) authorization of the plan at the time of the departmental workshop.

With respect to the implementation of integrated offer of services institutionalization, the actions to be taken as well as the indicators for tracking progress are identified and included in the summary table of actions and indicators for tracking the implementation of the plans for institutionalizing PROSAF results. Additionally, PROSAF trained the seven (7) coordinating physicians of the health zone on implementing the plan for institutionalizing the integrated offer of family health services. This training took the form of a technical meeting, during which the summary table of principal actions and indicators to follow for integrated offer of services institutionalization, conceived by PROSAF and handed over to each MCDZS, was reviewed, and its feasibility analyzed. Each HZMT must now micro-plan its implementation.

Continuous evaluation of excellence in integrated family health service in the health centers.

PROSAF discussed with the MCDZS and the HZMT training teams how to apply the evaluation grid for rating excellence in integrated services. The health zones decided to wait until all providers had been trained and to grant at least six weeks to the trained providers so that they could begin to apply what they had learned before their health center was rated for level of excellence in integrated offer of services.

Integrating integrated offer of services into the ENIAB educational curriculum

During this year, PROSAF supported the DDSP and ENIAB in implementing the first phase of integrated offer of services integration into the ENIAB educational curriculum. This first phase consisted of training ENIAB teachers in integrated offer of services and in the possible anchor points of this strategy of integrating the topic of health services into the educational curriculum. The general goal of this training program is to help teachers master the teaching techniques prepare educational sessions on the management of integrated offer of family health services, and to lead educational sessions on the management of integrated offer of family health services to help future providers graduating from the ENIAB offer accessible and integrated family health services to the people.

The learning goals demanded that ENIAB teachers be capable of:

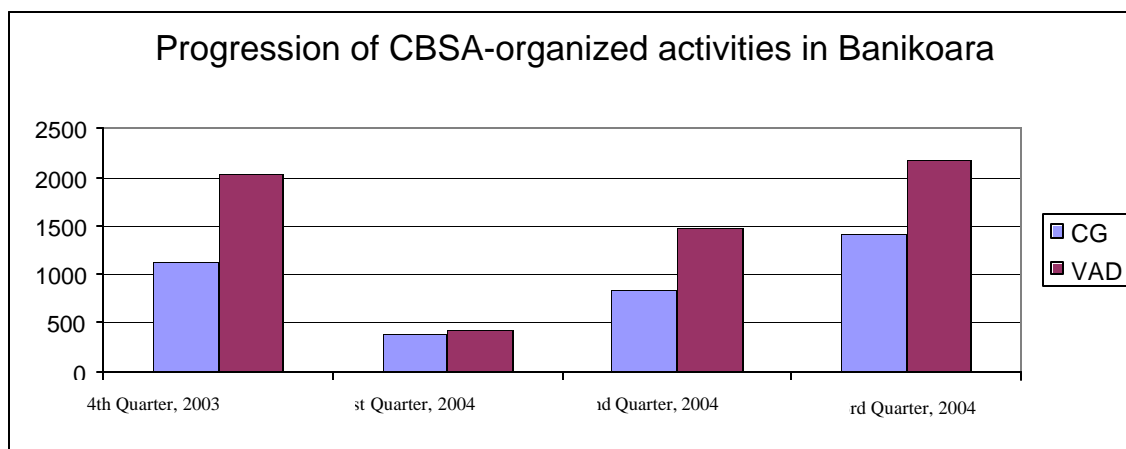
- Explaining the stages and tools of educational techniques.
- Explaining the principle concepts of the integrated offer of family health services.
- Describing logical links between the different integrated offer of services concepts.
- Applying teaching techniques to integrated offer of services education.
- Developing lesson plans on themes relating to integrated offer of services.
- Hosting a mini-teaching session.
- Evaluating a mini-teaching session.

Twenty-three (23) ENIAB teachers participated in this 5-day training program. During the first 3 days, the following themes were covered: 1) steps, techniques, and teaching tools, 2) Quality Assurance and the integrated family health services delivery, 3) the organization of integrated offer of services, 4) management of teamwork, 5) IPC and BCC for integrated offer of services. The fourth and fifth days of the training were devoted to the participants' development of pedagogical units on subjects chosen from topics developed during the first 3 days, and the presentation of these pedagogical units in the form of mini teaching. These mini teaching sessions allowed staff members to observe the ENIAB teachers' mastery of integrated offer of services concepts, as well as their ability to integrate them into pedagogical units, and transmit them during the teaching sessions. The next phase of the process will be devoted to the trained teachers' integration of integrated offer of services related themes into the ENIAB educational curriculum.

2.2.3 Sub-Intermediate Result 2.3: Availability of community-based products and services achieved.

Supervision of CBSAs in the former concentration zones

The community-based service network implemented with PROSAF financial and technical support in the health zones of Banikoara and Bembèrèkè/Sinendé had difficulties functioning during the first quarter of 2004. As shown in the graph appearing below, CBSA activities fell in the health zone of Banikoara. This decrease in performance can be linked to the irregularity of health agent supervision of the CBSAs. However, as the plan for institutionalizing the coordination and supervision of community-based activities began, a gradual increase is noted in the CBSA performance in both zones. Supervision will be strengthened in 2005 by PROSAF's coaching of the HZMTs.



2.3 Intermediate Results 3 Quality of services is improved

This result directly contributes to USAID/Benin's Intermediate Result 3, which is: *improved quality of services*. This result includes the following activities: strengthening capacity of health workers to manage health services through institutionalizing quality assurance, improving health worker performance at all levels through training, formative supervision, and coaching.

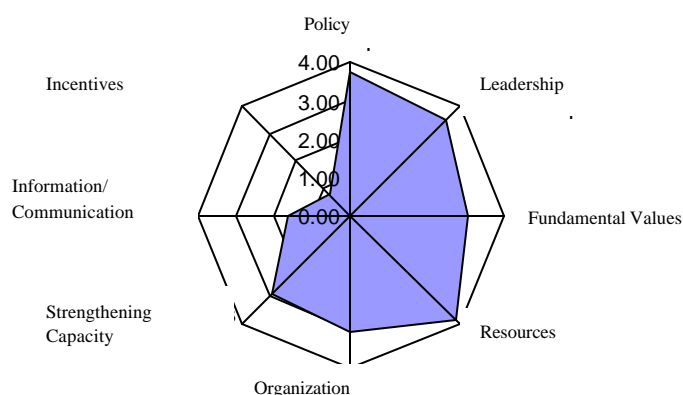
2.3.1 Sub-Intermediate Result 3.1: Health worker capacity to manage health services achieved.

Primary Accomplishments

- Development and implementation of the institutionalization plan for Quality Assurance in the departments of Borgou and Alibori.
- Extension of the Quality Assurance approach to all health zones in the departments of Borgou and Alibori.
- Rendering operational the collaborative model for network improvement.
- Training of 146 providers (health workers of all professional categories, including nurse's assistants) in the revised protocols for family health services in the departments of Borgou and Alibori.
- Training of 60 providers in EONC and 48 in IMCI
- Development of the plan to transfer responsibilities to the DDSP in order to implement performance monitoring of health care system.
- Development and tracking of implementation of plan for transferring responsibilities to the DDSP in order to develop and implement the integrated formative supervision of health workers.

With respect to Quality Assurance, PROSAF *Transition Phase*'s mission is to consolidate PROSAF results, and expand and make sustainable the processes and results that have significantly affected the quality of services and care. The reinforcement and cementing of results into the organizational fabric of the health system depends on proper management of the institutionalization process.² To this end, the PROSAF *Transition Phase* technical team worked within the technical frameworks of the DDSP and the health zone management teams rapidly assess the situation. This allowed the main factors influencing the progress of the seven health zones towards sustainability and quality assurance to be noted.

Status of factors influencing the sustainability of QA in Borgou/Alibori, April, 2004



The status of the eight factors presented was evaluated using a weighted scale from 0 to 5, which corresponded to the following stages: initial situation without any initiative (0 points); awareness (1 point); experimentation (2 points); expansion (3 points); consolidation (4 points), and maturity (5 points). Results of the assessment were presented and validated during a workshop, which took place in May 2004, and regarded plans for the sustainability of PROSAF methods and results. On this occasion, a participant noted the following: "From these results, I see that in Benin we don't have a

² **Institutionalization:** process by which the collective activities and values of an approach or strategy become a lasting and integrated part of a system or organization, and becomes part of daily routines and activities (staff is competent and committed to future actions; organizational policies and values are aligned in support of the goal sought).

problem with resources, but rather with incentive. It's the sharing of information that is lacking; the results reflect Beninese reality. How do you get people to work? What do people value? What are people interested in?"

Following this validation workshop, an institutionalization plan was drafted at the beginning of July 2004. This plan primarily aims to strengthen factors that support the process of improving quality in accordance with the collaborative model currently being piloted in the departments of Borgou and Alibori. These factors are: 1) on-going political support, 2) leadership, 3) fundamental values, 4) resources, 4) organization, 6) strengthening capacity, 7) information and communication, and 8) incentives and motivation.

Implementing this plan is one of the principle concerns of the PROSAF *Transition Phase* technical team. The work plan developed centers around four axes: (i) developing capacity in basic Quality Assurance; (ii) strengthening quality management; (iii) developing clinical improvements through the collaborative model; (iv) making the methods, tools, or results of the implemented Quality Assurance plan sustainable.

Initiatives are notable at the health zone level with respect to strengthening sustainability factors, such as leadership, for Quality Assurance. Four main events are of note:

- Designation by the DDSP Borgou and Alibori of a focus group for quality.
- Creation of improvement networks in collaboration with the neighboring departments of Zou and Collines.
- The increasingly strong involvement of the DDSP in follow-up visits to networks, serving as a reminder of the political commitment of the Benin MOH to Quality Assurance.
- Recording and including the progress of network activities in the points of discussion of the expanded CODIR meetings.

Additionally, certain health zones have developed and experimented with staff incentive systems, an important factor that is capable of influencing provider practices on a long-term basis with respect to their delivery of quality services and care.

Finally, the year 2004 was essentially devoted to strengthening capacity through workshops for sharing basic Quality Assurance concepts and coaching visits.

Extension of the Quality Assurance approach to all health zones of the departments of Borgou and Alibori.

The Quality Assurance approach has currently been extended to all seven health zones, covering both health centers and hospitals. Each health zone has access to a team that is competent in basic Quality Assurance concepts. The improvement projects cover two clinical domains, emergency neonatal and obstetrical care, and the integrated management of childhood illness. Two related areas are also taken into account, specifically: prevention of nosocomial infections and client satisfaction.

With respect to extending the Quality Assurance approach, it is useful to note that the experiences of the departments of Borgou and Alibori have since inspired the departments of Zou and Collines. These two departments are currently working in collaborative networks addressing the same four topic areas.

Operationalizing the collaborative improvement networks model

The creation of improvement networks has become the ideal framework for experimenting with the collaborative model. After a difficult start, the hospital teams are currently operational. Each hospital has put adequate infrastructures in place for conducting improvement activities in their respective domains. The teams have collected basic data and the majority have introduced rapid changes, and even planned other changes for which more resources or time are necessary for implementation. Here is the testimony of the chief physician at the Banikoara zone hospital, regarding the utility of introducing changes which lead to improvements:

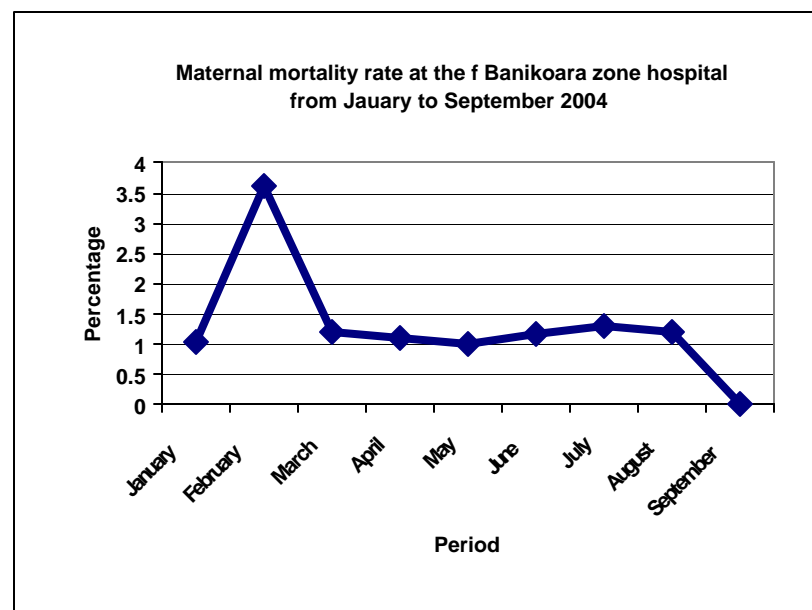
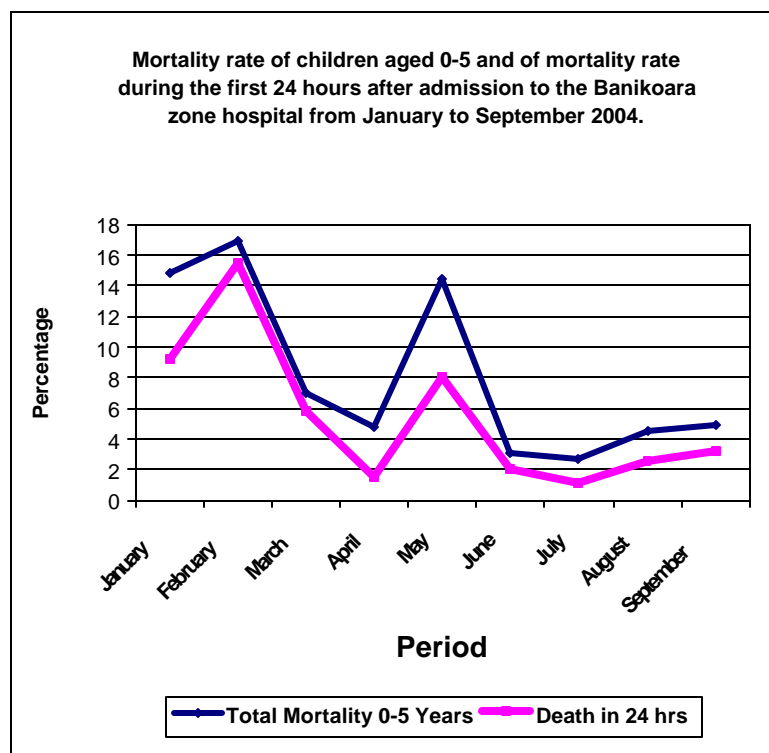
“Before, children and adults were hospitalized in the same wards of the internal medicine pavilion. But after the first workshop on improvement networks, held in May 2004, we decided to restructure the wards of our hospital. This allowed us to clear out a ward of 16 beds that currently serves as our pediatric services office. Using the same logic, we considered the recommendations given at the June 2004 workshop for launching improvement systems and created a system for Triage, Evaluation, and Treatment for Pediatric Emergencies. The mortality rate for children age 0-5 in the first 24 hours after admission was calculated, we noted a trend towards reduction starting in July, as soon as the intensive care unit for pediatric emergencies became operational.”

The follow-up visits organized by the DDSP team since the actual launch of systems in June 2004 allowed the necessary training to be given to the HZMTs and hospital staffs, so that clinical improvement activities could be carried out efficiently. Because of this, teams set up important initiatives, such as assuring the availability of emergency medications in the childbirth ward and the ward for sick children.

Networking became a means for developing partnerships for quality. PSS and PROSAF *Transition Phase* joined as partners in their efforts to increase the effectiveness of their interventions in the quality improvement process. This partnership allowed documentation and training programs required in prevention of nosocomial infections, EONC, and IMCI/Triage, Evaluation and Treatment of Pediatric Emergencies, to be made available in all health zones as well as the Departmental Hospital Center of Parakou.



Since the introduction of the changes, significant results have been reported. For example, when the hospital team created a pediatric service and a service devoted to emergency intensive care for sick children, even though children were mixed in with sick adults, a net improvement in care resulted. This translated to a tendency towards the reduction of the mortality rate of children from 0 to 5 years old, as well as the reduced mortality rate of this group during the first 24 hours in the Banikoara zone hospital, as illustrated by the graph below.



With respect to improving obstetrical care, particular emphasis was placed on systematically applying lifesaving procedures, and reorganizing the data collection system and services to record information regarding the different periods of treatment. All of the following measures resulted in a considerably reduced maternal mortality rate: making medication available in the childbirth ward, making surgical kits available for caesarians and respecting the norms for preventing infection in the maternity wards.

The implementation of improvement networks strengthened the collaborative teams that were already in existence since 2003. As part of the improvement continuum, each health zone team had to develop initiatives to ensure the continuity of the improvement activities begun in the health centers. The collaborative efforts on improving vaccinations or pre-natal care providers, childbirth, post-natal care and family planning, continue to be carried out by health center teams. Below is an example of how a midwife uses the collaborative model to develop the capacity of her coworkers to offer quality care. *“The collaborative model for improvement taught us that a treatment process could not be improved if all of the actors who are involved in its development don’t understand it in the same manner. Upon return to our maternity ward, I met with my colleagues, including midwives, nurses, and nurse’s assistants. Together, we discussed the steps that must be followed during prenatal consultation, assistance at birth, and family planning. This led us to identify superfluous steps, as well as steps that are indispensable but lacking. We have reconfigured the three processes to fit the care model. This has rapidly translated into the significant reduction of variances in the quality of treatment with respect to prenatal consultations, child-birth follow-up, and family planning providers.”* (Health zone of Malanville-Karimama.)

2.3.2 Sub-Intermediate Result 3.2: Health worker performance improved

Protocols and Integrated Proactive Offer of Family Health Services

Extension of the training in revised family health services protocols to all professional categories of the departments of Borgou/Alibori.

Training in the revised protocols of family health services was extended to all professional sectors of the departments of Borgou and Alibori, and was considered to be a key activity for promoting quality of care and services. Therefore, a training program for the physicians, nurses, midwives, and nurse’s assistants was developed and implemented in each health zone. The objectives of these training programs were to strengthen staff competency in order to:

1. Standardize family health services and care in all family health services.
2. Strengthen integration of PMA into the health training programs.
3. Improve provider performance.
4. Justify the care and services offered at each level, and ensure continuity from the community level to the hospital level of each zone.
5. Popularize new professional practices to improve quality of reproductive health services.

On September 30, 2004, out of a total of 826 planned providers, 146 received training on the revised protocols, a realization rate of 18%. The fourth quarter will mark the complete realization of these training programs according to the established schedule. Therefore, for the first time in Benin, all health workers in the two departments, including nurses’ assistants, will be trained in the content of the revised family health protocols, which includes all elements of proactive offer of family health services and significant amounts of IMCI and EONC.

Expand EONC training for midwives and IMCI training for nurses

EONC training

PROSAF *Transition Phase* contributed to the training of 20 midwives and nurses in emergency neonatal and obstetrical care (Tchaourou health zone) and PSS financed the training of 40 midwives and nurses of the health zone of Nikki/Kalalé/Pèrèrè, resulting in a total of 60 trained workers (42% realization rate) out of a total of 143 midwives and nurses selected for training in 2004. Additionally however, training in the revised protocols, which covered all professional divisions, included EONC while training all health zones who had never previously been trained in this sector. At the end of 2004, all health providers of

Borgou/Alibori will have had EONC training, including nurse's assistants, who play an important role in the healthcare system of Borgou/Alibori.

The zone management teams regularly conducted post-training follow-up visits to trained agents. Of note is the workers' effective utilization of the skills acquired from this training. For example, the testimony of this nurse, previously untrained, who tells of an experience she had, immediately upon her return from the EONC training.

"I never had any idea of what exactly had to be done when faced with a hemorrhage during birth. Well, what do you know, just after my training in EONC practice, I came into contact with a typical case. I applied all of the lifesaving procedures in order to perform the artificial birth, the venous approach with antibiotic coverage, and I transported the patient by motorcycle to the referral maternity center. We were three on that motorcycle, the driver, the women, and me, holding the glucose drip. That's how the woman was saved..." (Tchaourou health zone)

IMCI training

On September 30, 2004, 48 providers out of a recruited 129 were trained in IMCI (a realization rate of 37%). The training team regularly conducts post-training follow-up visits to workers trained in IMCI. The training of all health workers of Borgou/Alibori in the revised family health protocols, which contains an IMCI unit, is an asset for strengthening the competency of providers (including nurse's assistants) in offering care that respects the IMCI norms.

The recent launch of the improvement networks, one of which concerns the improvement of the Integrated Management of Childhood Illness, is the concrete framework for implementing the collaborative approach in health centers and reference hospitals, and increasing the percentage of workers that respect the IMCI norms. Particular interest has been given to treating cases referred by health centers to Departmental Hospital Center and zone hospitals. To this end, the training module on "Emergency Triage, Assessment, and Treatment" (IMCI for reference centers) was made available to each health zone, as well as to the pediatric service of the Departmental Hospital Center of Parakou.

Table 6: Health workers trained in IMCI in the four remaining health zones.

Proportion of health workers trained in IMCI by Health Zone						
	Bembèrèké Sinendé	Banikoara	Malanville Karimama	Nikki Kalalé Pèrèrè	Kandi Gogounou Segabana	Total
Number of health workers in the 5 non-IMCI health zones trained in IMCI	24	19	0	0	05	48
Total number of health workers in the 5 health zones selected to be trained in IMCI	36	19	37	32	05	129
Performance (Criteria fulfilled)	66.66%	100%	0%	100%	100%	37.2%

As part of the mission to consolidate PROSAF results, PROSAF *Transition Phase* helped the DDSP of Borgou/Alibori develop a plan for implementing health system performance monitoring and the integrated formative supervision of health workers. These plans were validated in May 2004 during a national workshop.

Formative supervision is the process of directing and supporting healthcare staff, so that they can assume responsibilities according to the norms and protocols for treatment and management. The formative supervision process aims to improve worker performance by simultaneously working on the competencies, motivation, and work environment of health workers, both at their work posts, and during care provision. Formative supervision allowed immediate feedback on the behaviors observed and the deficiencies noted with respect to mastery of given task, or a series of actions of which the task is composed.

During 2004, 51% of health centers benefited from formative supervision during the first quarter, 78.2% during the second quarter, and 66% during the third quarter. This variance is largely explained by the frequent disruptions in the HZMTs' activities schedule due to the management of epidemics.

Table 7: Health center performance in formative supervision, by health zone of Borgou/Alibori during the first, second, and third quarters of 2004

Period	Bembèrèkè Sinendé	Banikoara	Malanville Karimama	Parakou N'dali	Nikki Kalalé Pèrèrè	Kandi Gogounou Segbana	Tchaourou	Total 7 Health Zones
Quarter 1	2/13 (15%)	10/10 (100%)	5/10 (50%)	12/12 (100%)	0/31 (0%)	20/23 (87%)	5/6 (90%)	54/105 (51%)
Quarter 2	13/13 (100%)	11/11 (100%)	10/10 (100%)	13/15 (93%)	17/31 (53%)	18/23 (78%)	4/7 (57%)	86/110 (78.2%)
Quarter 3	11/13 (84.6%)	8/11 (72.7%)	6/10 60%	15/15 100%	8/31 (0%)	18/23 78.3%	7/7 100%	73/110 (66%)

Additionally, certain health zones, including those of Malanville/Karimama, frequently fail to report in the supervisory books and records that the health workers have been observed during the care provision which is an essential criteria in formative supervision. As this criterion has not been reported in the principle information sources, the supervisory visits are not considered as training.

Formative supervision currently serves as the framework for strengthening worker competency in the treatment of obstetrical complications. Following the testimony of a coordinating physician for the health zone of Bembèrèkè/Sinendé: *"From the moment our health zone decided to enroll in the improvement network for EONC treatment, we began to examine all our reference sheets for cases received at the arrondissement health centers from January to June 2004. This allowed us to identify the deficiencies linked to non- mastery of the treatment process, particularly the correct and incorrect actions to take. From the compiled data, we established a formative supervision program. Now that the required actions have case references, they have started to become automatic to the midwives or nurses working in the maternity wards of peripheral health centers. Thanks to this experience, we decided to institute a practical and structured training program in the maternity ward of our zone hospital."*

2.4. Intermediate Result 4: Increased Demand for Health Services and Preventive Measures

This intermediate result contributes to the USAID/Benin's Intermediate Result 4: *increased demand for health services and prevention measures*. Activities carried out to achieve this result include: improving community knowledge and attitudes of prevention measures and appropriate behaviors; fostering a socio-cultural environment that favors the use of services and prevention measures.

Primary Accomplishments

- 20,000 spectators from 65 villages reached in the Bariba and Boo languages by HIV-AIDS prevention and family planning activities.
- 9 radio spots developed, recorded and broadcast by seven radio stations in 4 local languages.
- 7 Supervisors of Social Mobilization and Behavior Change Communications (BCC) trained in IECC/BCC.
- BCC curriculum developed, adopted, and incorporated into the CBSA training curriculum.
- 16 trainers trained in BCC curriculum.
- A *Participatory Steps against AIDS* curriculum developed and tested by two NGOs.
- 3 songs about IMCI and community EONC developed and broadcast by radio.
- 5,000 posters and 2,200 counseling cards on diarrhea prevention developed, tested, reproduced, and distributed.
- 38 memorandums of understanding signed through 134 community workshops

Throughout the year, many efforts were made to conduct behavior change communication activities to sustain PROSAF results. Innovative, culturally appropriate communications strategies were used in a comprehensive approach that emphasized the responsibility of communications supervisors at the department and health zone levels and the strong involvement of the different communications representatives at the community level (health workers, radio hosts, comedians, griots and singers, community forums, and NGO organizers). The following describes the strategies used, the activities conducted and the accomplishments recorded. A Knowledge, Attitudes and Practices (KAP) survey will be conducted in 2005 to determine the level of impact that these activities have had within the populations of Borgou/Alibori.

2.4.1 Sub-Intermediate Result 4.1: Improvement of knowledge and attitudes favoring prevention measures and appropriate behaviors

Strengthening and expanding Behavior Change Communication activities in all *communes* in the departments of Borgou/Alibori.

Community theatre to raise people's awareness

To increase the population's demand, tours of two theatrical plays were conducted, and a third begun. The play *Let's fight against AIDS* was presented before 10,000 spectators in 30 *commune* villages of Pèrèrè/Nikki/Kalalé, and Gogounou, which were not covered in 2003. The people's knowledge of each of three major methods of avoiding AIDS increased by more than 50%. The play *Let's space out births* was translated into Boo and presented in 35 villages before 10,000 spectators. The rapid participatory survey shows a significant decrease in the desired, or ideal, family size among Boo spectators. Also, knowledge of the three methods of contraception went from 32% to 87% during the course of the participatory survey, conducted before and after the theatrical presentations. A play on community EONC and the reasons to trust these modern family planning methods was developed and presented in seven villages. The tour is on-going.

Many efforts were made to strengthen the existing competency in community theater in the Borgou/Alibori. Indeed, the Bio Guerra troupe performed plays, accompanied by group activities and rapid participatory surveys, with increasingly less technical assistance. For the AIDS play, the troupe secretary and manager learned how to develop questions and analyze the data from the rapid participatory survey (both manually and on Excel). Using the EONC modules and family planning modules of the *BCC Curriculum*, the troupe developed the EONC/Family Planning play without a development

workshop. Furthermore, ABPF began replicating the play *Let's space out births* for Boo populations. The association arranged for the translation and adaptation of the play, and trained a community theater in Boo. The theater received technical assistance for the staging.

Use of rural radios to broadcast spots and songs

Radios are a very efficient means of communication to reach the largest possible percentage of the population, and to thereby contribute to improving that population's knowledge. This plays a part in encouraging the demand for services and prevention measures, given that more than 64% of women and 84% of men listen to the radio several times per week. Contracts for distributing spots and songs were signed with seven radio stations. The stations broadcast spots on condoms in four local languages (Dendi, Bariba, Peuhl and Boo). The people were encouraged to use condoms, in addition to other contraceptive methods, in a double-protection approach: protection against undesired pregnancy, and protection against STIs and HIV/SIDA. Songs on the EONC danger signs, and the methods for avoiding diarrhea were developed.



Group of women during the song development workshop

To strengthen the capabilities of radio hosts in the areas of IMCI and community EONC, a workshop for developing spots and songs concerning these themes was organized. Participating in this workshop were: hosts from four local radio partners, two new, local radio stations, and one folklore group from one of the local radio partners. By the end of the workshop, nine spots were recorded in Bariba, eight in Dendi, six in Boo, and six in Peuhl, as well as five songs that were sung in at least four of the languages spoken in Borgou/Alibori.

The spots and songs addressed the following topics, which are key to implementing IMCI and community EONC: vaccination, diarrhea and the danger signs in children, the means for preventing diarrhea, and the perceived secondary effects of family planning. These spots and songs are broadcast in the communities of Borgou/Alibori by radio campaigns, griots, and even women's groups, and will continue to be throughout the first semester of 2005.

During this year, in response to efforts to raise health worker awareness on the necessity of working with communications actors to raise awareness of health issues, three health zones formed partnerships with local radio stations to broadcast health messages. These zones were Banikoara (which has financed radio programs with community funds for years), Bembèrèkè/Sinendé, and Tchaourou (where supervisors of Social Mobilization – Behavior Change Communication [SM-BCC] began to produce and broadcast programs on family health themes in cooperation with local radio stations). This attitude is consistent with the sustainability framework for BCC activities which, thanks to PROSAF technical support, has both a source of funding and competent management personnel.

Strengthen communication between actors, health workers, the COGECs, and VHCs, and the capacity to undertake BCC and social mobilization activities.

Sustainability also depends on the capacity of communications workers to continue promoting KAP changes without technical assistance. The training program for Supervisors of SM/BCC, who are the focal points at the zone level, gave these supervisors the skills necessary for ensuring the continuity of SM and BCC activities at the zone level. An orientation workshop initiated them in management, BCC concepts, and in incorporating BCC activities in community-based integrated offer of services. During this session, they also completed and integrated SM/BCC activities into the health zones' 2004-year action plans.

The *BCC Curriculum* and the *Curriculum for Training Community Liaisons* incorporated both the BCC Curriculum and the IEC advertising mediums on Community IMCI and EONC (see above), permitting health workers and community facilities to better communicate and promote family health behaviors. The workshop for developing and validating the *BCC Curriculum* brought together health workers, NGOs, and PROSAF field workers and partners. This curriculum consists of a usage guide, facilitation techniques, and interactive modules on BCC and the principal topics of family health. Seven supervisors of SM-BCC and nine ozone animators from ABPF were trained in the Curriculum as teacher trainers. Additionally, improvements were made to the curriculum.

The Director of the IEC Division of the DDSP/B-A, along with a teacher from the ENIAB, with the technical support of the PROSAF BCC team, trained 23 ENIAB Teachers in BCC and interpersonal communications (IPC) during their training in integrated offer of services. The HZMTs of Parakou-N'Dali also trained the health workers of the Hospital of Boko in IPC.

Strengthen the capabilities of community volunteers and members of community-based organizations, women's groups and local associations, and NGOs, to implement BCC.

A curriculum for training community liaisons in the fight against AIDS, *The Participatory Steps Against AIDS*, was developed and used to train members of the APID, GRADE, ABPF and Bio Guerra NGOs. The Grade and CAPID NGOS, with PSS and PROSAF technical assistance, are experimenting with it in four villages and city neighborhoods in the *communes* of Nikki, Kalalé and N'Dali. A draft of the second part of the curriculum is being developed with the participation of the National Program for the Fight against AIDS (PNLS) unit of B/A.

2.4.2 Sub-Intermediate Result 4.2: Improving the socio-cultural environment favoring the use of services and preventative measures has improved.

Supporting the implementation of IMCI and community EONC in Borgou/Alibori in collaboration with other partners.

PROSAF and other participants in community IMCI (MCDI and PSS) and EONC (IntraHealth International) held several meetings in order to synchronize the approaches for implementing their strategies. In each health zone, the following activities were implemented, with the technical and/or financial assistance of these different partners:

- Development of a protocol for implementation;
- Identification of health centers for implementing each of the strategies;
- Training of community facilitators;
- Negotiation of community partnerships;
- Participatory community-level assessment.

Each health zone identified the health centers where the above-cited actions were developed as pilots. In the health zone of Malanville/Karimama, community EONCs (SONU-c) covered the villages and the health areas of the CSA while the health zones of Nikki/Kalalé/Pèrèrè (six CSAs) implemented community IMCI (PCME-c). Overall, four CSAs implemented community EONC and 14 CSAs implemented PCIME-c.

In conjunction with the implementation of the health training process, and in accordance with the multi-sector platform recommended for executing community IMCI, 18 teams of 97 Community Facilitators were established. On the whole, these teams are comprised of a head post nurse, a midwife, CARDER workers, community leaders, organizers of local NGOs, and zone organizers of the ABPF. These teams were trained according to an iterative system, so that they be able to carry out all of the process steps. During this year, the main steps achieved were negotiation of community partnerships and participatory community-level assessment.

Negotiating community partnerships

The negotiation of community partnerships is sub-divided into four steps: The immersion stage, making contact with arrondissement-level authorities, meetings for research support at the village level, and meetings at the arrondissement level to confirm the support of villages in the program. 81 meetings were held, both at the village and arrondissement level, with 5,405 participants, including 1,256 women. By the end of these meetings, all 123 targeted villages and hamlets had made a formal commitment to EONC or community IMCI.

Participatory community-level assessment

Participatory community-level assessment is the step during which the problem of elevated morbidity and mortality of children aged 0-5 in the health zones implementing community IMCI, and the neonatal and maternal mortality rate for the health zone implementing the community component of EONC, are analyzed. A team in each village, using a rapid problem-solving approach, conducts this analysis. Indeed, each village formed a team consisting of local authorities, resource people from the different participating milieu, as well as opinion leaders, and representatives of corporations and associations. This team collects and analyzes baseline data used for problem identification. Baseline data consists of, among other things, the data collected by the facilitation team at the time of immersion, SNIGS data, data available at the level of the Social Promotion Centers (CPSs) and NGOs, the surveys (DHSs), and supplementary data collected within the community. With the base of data collected, each village team identifies the problems, researches the causes, and verifies them in order to determine the principal causes. At the end of this stage, each team prepares solutions, defines the most relevant priorities, identifies the actions to test and carry out, and develops an implementation plan. This plan contains the actions to implement at the village level, but also records actions pertaining to the arrondissement level, to be recorded in the action plan of the arrondissement health center. These action plans equally incorporate the delivery of community-based health services, the integrated promotion of key practices, and the strengthening of community partnerships.

Overall, 134 workshops, with 3055 participants, including 300 women, were held in order to achieve this process. Collectively, out of 85 arrondissement health centers in non-targeted health zones, 38 centers each developed and signed a memorandum of understanding with the relevant communities in its health area (38 MOUs were signed). These MOUs are the official realization of the commitment given during the preceding phase. The villages that signed the memorandums of understanding with the health centers in the non-concentration health zones are as follows:

Table 8: Communities/villages who have signed a memorandum of understanding with non-concentration zone health centers

COGEC PERFORMANCE						
	Malanville Karimama	Parakou N'dali	Nikki Kalalé Pèrèrè	Kandi Gogounou Segbana	Tchaourou	Total
Number of villages in non-targeted zones who have signed a memorandum of understanding with their health centers	72	79	0	108	43	302
Total number of recruited villages in non-targeted zones	72	79	217	123	43	534
Performance (criteria fulfilled)	100%	100%	0%	88%	100%	57%

The final product of participatory community-level assessment is the development of action plans for resolving the problems identified. The health centers and villages in the five non-concentration health zones that currently have available 2004-2005 action plans are as follows:

Table 9: COGEA/VHCs that have available 2004 & 2005 actions plans, by non-targeted health zone

	Malanville/ Karimama	Kandi/ Gogounou/ Ségbana	Tchaourou	Nikki/ Kalalé/ Pèrèrè	Parakou/ N'Dali	Total
Number of COGEAs who have available action plans ³	9/9	21/24	6/6	0/33	2/13	38/85
Number of villages (VHCs) with available action plans in the concerned arrondissements	25/25	19/37	24/24	0/51	10/10	78/147

These action plans have begun to be implemented in the towns with established community-based services. The process will continue in the towns not yet having action plans during the fourth quarter of 2004.

Identification of CBSAs, VHCs, and other community structures

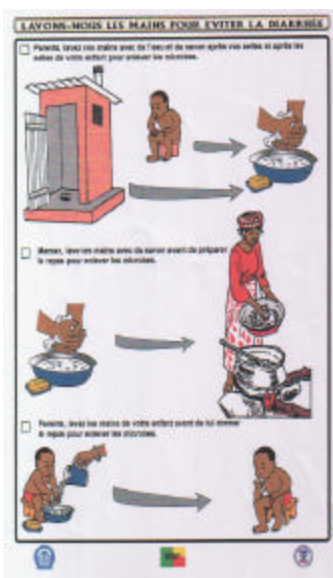
Choosing CBSAs is one of the first activities of services delivery, which is one of the three elements in the conceptual framework for implementing the community component of IMCI. After completing participatory community-level assessments and village action plans, the structures for implementing community-based services are gradually put in place. They are added to the framework already established during the first phase of PROSAF. Currently, the breakdown for the establishment of these structures in the previously untargeted zones is as follows:

³ Including arrondissements not implementing the community components of IMCI and EONC.

Table No. 10: Breakdown of the establishment of community-based service delivery structures

	Malanville/ Karimama	Kandi/ Gogounou/ Ségbana	Tchaourou	Nikki/ Kalalé/ Pèrèrè	Parakou/ N'Dali	Total
Number of CBSAs	30	12	12	ND	12	66
Number of VHCs	25	12	12	ND	12	61
Number of traditional birth attendants	0	0	32	ND	30	62
Total CBSAs in the health zone	54	43	43	ND	36	176
Total VHCs in the health zone	49	43	43	ND	ND	135

Development and production of IEC advertising materials for IMCI and community EONC



In order to support IMCI and community EONC, songs and printed advertising materials were developed. Songs help the population to prevent diarrhea and to recognize the danger signs in children and pregnant women. They were developed through participatory IEC advertising materials so that the population could sing them themselves, and convey the messages at their own pleasure, without the intervention of specialized communication assistance. 5 local radio stations broadcast the EONC song daily. A guide for teaching this song was developed so that the CBSAs can teach it to the people. This guide is complemented by a gestures game on danger signs. The song, guide, and gestures game were incorporated into the *Curriculum on Training Community Liaisons*.

In order to better transmit messages on diarrhea prevention, posters and counseling cards were developed from images of the *Child health booklet*. In all, 5000 posters (2500 on the contamination cycle and 2500 on prevention [picture above],) and 2200 counseling cards were printed in color. The SM/BCC Supervisors received the packs of counseling cards for the CBSAs, which will be distributed during their training in the community liaison

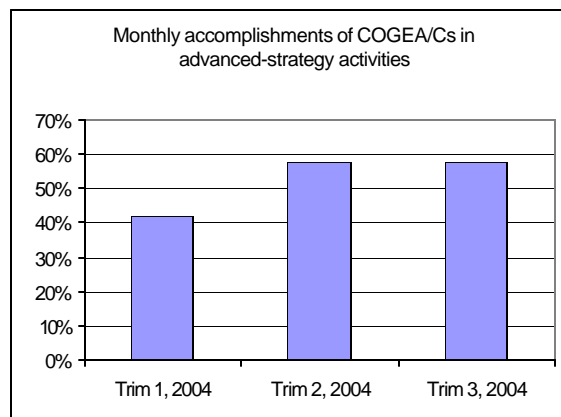
curriculum.

The play on EONC and the perceived side effects of family planning, developed by the Bio Guerra troupe, will be broadcast in the two health zones that chose EONC (Banikoara and Bembéréké-Sinendé), as well as in some villages of Nikki, N'Dali, and Pèrèrè, during the fourth quarter of 2004 and throughout the first half of 2005.

Strengthen the capacity of COGEAs and VHCs to improve their participation in health activities, including income-generating activities

Participation of COGEAs in advanced-strategy activities

PROSAF was interested in the effective participation of COGEAs in the monthly execution of advanced-strategy activities, such as vaccinations, IEC/BCC, healthy children consultation, nutritional surveillance, and prenatal consultation. The performance achieved in this area remained at the same level for the two final quarters of the year, as indicated by the graph opposite.



More than half of the COGEAs in the seven health zones accomplish advanced strategy activities monthly, in collaboration with the health teams. This performance will be gradually improved as the operational capabilities of COGEAs in the untargeted zones are strengthened.

Tracking Income Generating Activities (IGAs) in the health zones of Banikoara and Bembèrèkè/Sinendé

The seven pilot arrondissement health centers of Banikoara and Bembèrèkè/Sinendé, and the health center of Toura each received several support visits from the supervisors of social mobilization and behavior change communication and from the PROSAF technical assistants. The IGAs conducted at these centers are: the Village Boutique in Ina, the Marketing of Petroleum (which constitutes 50% of IGAs) in Kokey, Founougo, Ounet and Toura, the production and marketing of ice cream and bllipops in Sèkèrè , the canteen in Fo-Bouré and the bush taxi in Gamia. Out of the total funding needed for implementing these activities, the communities contributed a remarkable 33%. The IGA in Toura was entirely financed by internal resources mobilized at its arrondissement level. Four (4) IGAs were co-financed by the communities and PROSAF, and three (3) were entirely financed by PROSAF.

The launch of activities in the first seven centers coincided with the end of the first stage of PROSAF. Currently, six IGAs out of eight are functioning normally. They could reach optimum performance with a little more systematization in supervision and management assessment. The IGAs of two other health centers are having difficulties and have suspended operations in order to re-define them. The principal difficulties that were recorded were not rigorously applying management rules and procedures, lack of supervision on the part of the HZMTs in the health zones of Bembèrèké-Sinendé; and irregularity of stocks of petroleum products of the SONCOP in the health zone of Banikoara. After the supervisory visits were conducted, a certain number of recommendations were made: collectively re-reading IGA management procedures; integrating IGAs into health center management supervision; restructuring non-performing committees; and effectively applying reimbursement plans.

Despite the constraints certain IGAs are experiencing, this activity is gaining more and more enthusiasm, and the HZMT members are increasingly taking the management of these activities in hand. During the planning of the 2005 activities, 8 COGEAs in the health zones of Bembèrèkè/Sinendé, Parakou N'dali, and Tchaourou, showed an interest in experimenting with IGAs, by budgeting for an IGA. COGEC performance with regard to new IGA proposals appears below.

Table 11: Innovative proposals for income-generating activities

COGEA PERFORMANCE								
	Bembèrèkè/ Sinendé	Banikoara	Malanville Karimama	Parakou N'dali	Nikki/ Kalalé/ Pèrèrè	Kandi/ Gougounou/ Segbana	Tchaourou	Total
Number of innovative proposals for income-generating activities, drafted by COGECs and sent to HZMTs	06	04	0	04	0	01	01	16
Total number of COGEAs/ COGECs	13	11	10	12	31	23	06	106

3. PROGRAM MANAGEMENT

3.1 Support to the DDSP and health zones

The Borgou/Alibori DDSP, its affiliated facilities, and the seven (07) health zones were supported throughout this year by PROSAF *Transition Phase* financial and technical support. Following are some highlights of that support:

- DDSP needs and availability of computer equipment were assessed to strengthen computer capacity and network the computer system.
- Support was provided to the DDSP and seven (07) health zones in the form of computer equipment consisting of seven (7) laptop computers and accessories, one (1) desktop computer, one (1) inverter, one (1) overhead projector for transparencies, and one (1) multimedia numerical overhead projector to strengthen data management and planning capability.
- The National School of Assistant Nurses of Benin (ENIAB), based in Parakou, also received financial support throughout the period from PROSAF through the installation of a communications system based on New Tools for Information and Communication (NTIC) and also from computer equipment and multimedia materials consisting of one (01) IBM ThinkPad laptop and accessories, one (01) laptop bag, one (01) InFocus LCD Projector Model, one (01) Overhead projector for transparencies, one (01) multi-outlet APC and one (01) voltage regulator.
- A delegation of the MOH, consisting of the DDSP/BA and two technical team members of PROSAF *Transition Phase* participated in the Global Health Council conference held in the United States from May 28 through June 11, 2004 in Washington, DC.

3.2 Staff

The necessary team for implementing PROSAF *Transition Phase* is completely in place. Currently, there are a total of forty-two (42) workers available to ensure the technical and administrative management of PROSAF *Transition Phase*.

3.3 Management of supplies and material

With regard to program management, the computer equipment of the technical and administrative staff at the PROSAF office in Parakou was replaced at the beginning of the year.

Two (2) new vehicles were purchased and three (3) old vehicles were repaired. The vehicles should bolster the vehicle fleet and facilitate the movement of technical staff in the field.

In response to the electrical problems that the city of Parakou faces, three (3) generators were ordered, received, and installed in the three (3) PROSAF residences.

Repairs and maintenance were also completed on the motorcycles of Technical Assistants and ABPF hosts to facilitate their travel to their posts in the health zones;

3.4 Consultant Management

The following consultants were hosted by the PROSAF field office during the year:

- Volkan CAKIR, Consultant: To support PROSAF in the development of its Sustainability Plan.
- Tonja R. CULLEN, URC/PROSAF Program Officer: Traveled twice to Benin: 1) to provide technical support for the implementation of the program, the recruitment and training of a new administrator, the finalization of the Plan for PROSAF *Transition Phase* Performance Monitoring, and the development of the first draft of the final report for the first phase of PROSAF and 2) to develop job aids and begin operational research on incentives.
- Fritz BAFOUR, Consultant: Traveled from June 20-25, 2004 to conduct reconnaissance of sites for a documentary, deepen knowledge of PROSAF history, identify a site where the filming could be completed, edit the documentary filmmaker's script, and determine the timeline for filming the video. Also traveled from July 18 - July 25, 2004, to film the documentary on Community Mobilization.
- Thierry GOUTONDI, Consultant: To support PROSAF's development of the training module and tools for implementing quality assessment of health data.
- Siri WOOD, PATH Technical Backstop for IEC/BCC: From September 5 - 18, 2004 to assist the BCC team to plan activities for the fourth quarter of 2004, and to help improve the BCC curriculum prepared for the CBSA training program.
- Cyrille ZOUNGAN Consultant: To support the PROSAF *Transition Phase* team in data analysis for the Rapid Evaluation of Health Worker Performance, 2nd edition (ERPA-2).

3.5 Contract Management

The contracts for the leases of offices and residences of the Deputy Chief of Party, QA Specialist, and Chief of Party were renewed and signed by URC.

With respect to the management of local consultants, a contract was drafted and signed with consultant Thierry GOUTONDI for the development of training modules and to implement quality control tools for health data and another contract with consultant Cyrille ZOUNGAN for his support to PROSAF *Transition Phase* in data analysis of Rapid Evaluation of Health Worker Performance, 2nd edition (ERPA-2) at the departmental level.

Contracts were drafted and signed by ORTB (Regional Radio of Parakou) and by six (06) community radio stations to facilitate the broadcast of radio spots on family health themes.

To raise awareness about Emergency Neonatal Care and Family Planning (EONC/FP) through the theater piece *Let's protect our mothers and children* to be performed in the villages of Alibori and Borgou, an additional contract was drafted and signed by the theater troupe BIO GUERRA to conduct the pre-test and tour of the play in sixty-four (64) targeted villages.

All contracts were properly followed, and disbursements were made in accordance with the clauses established in each contract.

4. PROSAF Transition Phase Annual Financial Report 2004

Period: January 11 to September 30, 2004

Contract No: 680-C-00-04-00039-00

Contract Cost	\$3,809,449
Fixed Fee	\$190,472
Total Contract Amount	\$3,999,921
Current Obligation	\$3,100,000

Contract Line Item	Total Estimated Budget	Actual Expenditures to Date	Required Funding for 2005
IR 1: Improved Policy Environment	\$878,228	\$322,800	\$555,428
IR 2: Increased Access to Family Health Services and Products	\$833,214	\$281,752	\$551,462
IR 3: Improved Quality of Services	\$783,518	\$342,951	\$440,567
IR 4: Increased Demand for Health Services and Prevention Measures	\$1,504,961	\$532,830	\$972,131
Total	\$3,999,921	\$1,480,333	\$2,519,588

Total Expensed Funds	\$1,480,333
Total Obligated Funds	\$3,100,000
Total Obligated Funds Remaining	\$1,619,667

Total Fee	\$190,472
Total Fee Billed	\$41,411
Fee Remaining to be Billed	\$149,061